

Medicaid



Montana Medicaid Certificate of Medical Necessity

Durable Medical Equipment (DME) and Supplies (Rev. October 2014)

Augmentative Communication Device	
Section A	
Patient Name, Address, Telephone Number, and Date of Birth	Physician Name, Address, and Telephone Number
Medicaid ID Number _____	NPI Number _____
Residence <input type="checkbox"/> Home <input type="checkbox"/> Nursing Home <input type="checkbox"/> Hospital Rehab Unit <input type="checkbox"/> Group Home <input type="checkbox"/> Other _____	
Diagnosis	Estimated Length of Need (Months): _____ 1-99 (99=Lifetime)
Prognosis for unassisted communication?	
What is the anticipated benefit with a device?	
Date of Last Evaluation by Speech Therapist Attach evaluation.	Therapist's Name
Section B	
1. Has the patient received a trial in the use of this device? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Does patient have the physical and mental ability to operate the device? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Can the patient or caregiver be responsible for the maintenance of this device? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Functional limitations of the patient? <input type="checkbox"/> Contractures <input type="checkbox"/> Paralysis <input type="checkbox"/> Ambulation Impaired <input type="checkbox"/> Comatose <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Respiratory Disease <input type="checkbox"/> Disoriented <input type="checkbox"/> Other (Explain) _____	
5. Does this device have environmental controls? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Narrative description of all items, accessories, sizes, and options, including model numbers to be included in this section. If additional space is needed, a continued narrative can be attached to this document as long as the pertinent patient and physician information is included at the top of the attachment. Physician's signature must also be included on the attached document. <input type="checkbox"/> Yes, attachments are included. <input type="checkbox"/> No, attachments are not included.	
I certify that I am the treating physician identified in this form. I certify that the medical necessity information contained in this document and its attachments are true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.	
Signature and date stamps are not acceptable.	
_____	_____
Physician's Signature	Date (mm/dd/yyyy)