

Physician Prescription

Patient Information

Patient Name: _____

Patient DOB: _____ Patient Medicare Number: _____

Patient Address: _____

Diagnosis Code (ICD 9): _____ (Must be completed by physician)

I have reviewed a copy of and agree with the Speech-Language Pathologist's completed Augmentative Communication Evaluation for the subject patient. The prescribed speech generating device and accessories are necessary to achieve the functional communication goals stated for this patient in the Speech-Language Pathologist's treatment plan and to provide on-going medical care.

RX:

Length of Need (# of Months) 1-99 (99= lifetime): _____ (must be filled in by physician)

MEDICALLY NECESSARY

Physician Information

Physician's Name (print): _____

NPI #: _____ Phone #: _____

Medicaid Provider # : _____ UPIN# _____ License #: _____

Address: _____

Physician's Signature: _____ **Date:** _____