

Speech Generating Device (DME) Prescription

1. Patient

Last name: _____	First: _____	Middle: _____	Birth Date: ____/____/____
Address: _____	City: _____	State: _____	Zip: _____

2. Diagnosis

Primary Diagnosis: _____	Diagnosis Code (ICD-9): _____.
Secondary Diagnosis: _____	Diagnosis Code (ICD-9): _____.
Third Diagnosis: _____	Diagnosis Code (ICD-9): _____.

3. Prognosis: _____

4. Medical Necessity: _____

5. Length of Time: _____

6. Prescription: _____

7. Physician

I have reviewed the evaluation of the patient indicated above and concur with the recommended speech generating device and deem each of the items listed to be reasonable and necessary for the treatment of the patient's expressive communication diagnosis and necessary to achieve the functional communication goals stated in the Speech Language Pathologist's treatment plan. Additionally, I hereby certify that I do not have a financial relationship with, nor will I receive any other gain from, the manufacturer of the recommended device.

Name (print): _____
Address: _____ City: _____ State: _____ Zip: _____ Tel: (____) ____ - _____
UPIN: _____ Medicaid ID: _____
Signature: _____ Date: ____/____/____