CERTIFICATE OF MEDICAL NECESSITY

DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 522 (6-2006)

Clear Fields

SPEECH GENERATING DEVICE

SECTION A - Certification Type/Date:

Date	☐ Initial ☐ Revised
Name	Patient ID

SECTION B - Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

What is the anticipated benefit with a device?

1. Date of last evaluation by speech therapist. (Attach evaluation)	Therapist name:
2. Date of last evaluation by physician.	Physician name:

3. Has the patient received a trial in the use of this device? ☐ Yes ☐ No

4. Does patient have the physical and mental ability to operate the device? ☐ Yes ☐ No

5. Can the patient or care-giver be responsible for the maintenance of this device? ☐ Yes ☐ No

6. Functional limitations of the patient:

☐ Contractures ☐ Paralysis ☐ Ambulation Impaired ☐ Muscle Weakness ☐ Respiratory Disease

☐ Disoriented ☐ Other- Please Explain: _____

7. Does this device have environmental controls? ☐ Yes ☐ No

SECTION C - Narrative Description

Narrative description of **ALL** items, accessories and options etc., to included model numbers 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 in the attached document).

SECTION C Physician Signature/Date

Signature	Date	(Signature and Date Stamps are not acceptable)