Physician Prescription/Certificate of Medical Necessity

Patient Information ***Order Date:***

Patient Name:

Insurance ID: Address:

Patient City: State/Province:

Zipcode: Birthdate of Client:

Phone number:

Augmentative Communication Consultants, Inc.
P. O. Box 731, 600 Commerce Drive
Moon Township, PA 15108
Phone: 412 264-6121 Fax: 412 269-0923
www.acciinc.com acci1@earthlink.net

Patient Status (To be completed by the prescribing physician)

Clinical Information

Diagnosis: (Medical and/or Speech):

ICD Codes:

Length of Need: ☐ Lifetime Other:

Date of last face-to-face visit (must be within last 6 months):

Equipment Prescribed

Equipment to be: ☐ Purchased ☐ Rented

Equipment Description	Quantity

Mount needed: (choose one) ☐ YES ☐ NO

Physician Information:

I have reviewed a copy of the Speech Language Pathologist's completed communication evaluation for the above patient, in a face to face encounter, and agree with the recommendation for the listed equipment. I certify that this patient has a medical condition resulting in a severe expressive speech disability and that speaking needs cannot be met using natural communication methods. I also certify that the patient's communication will benefit from the medical device and that other forms of treatment have been ruled out. My prescription is based on the evaluation that I have reviewed and concur with, made by the Speech Language Pathologist, of the patient's physical, language and communication abilities and needs. I agree that the device is medically necessary for the patient's health.

Physician's Printed Name: NPI:

Physician Medicaid Provider ID: Phone: Fax:

Address:

Physician Signature: Date:

Signature/Date stamps are not permitted

Return via fax to: 1-412-269-0923 or via e-mail to: acci1@earthlink.net