

Physician Prescription

Patient Information

Patient Name: _____

Patient DOB: _____ Patient Insurance ID 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 is 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: Please check ONE

- Pocket Communicator
- Communicator PC10
- Communicator U8
- Communicator Q1
- Communicator U1
- Communicator TB19
- Communicator 6000

MEDICALLY NECESSARY

Physician Information

Physician's Name (print): _____

NPI #: _____ Phone #: _____

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

Address: _____

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