Assistive Communication Device Request Form

PATIENT: Name: _____

ID: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

REQUESTING PROVIDER: _____ ID: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

VENDOR: _____ ID: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Requested Date: _____

ITEM DESCRIPTION	QTY	LIST PRICE	HCPC	MODIFIER

PLEASE ATTACH THE FOLLOWING INFORMATION:

☐ Evaluation completed by a licensed speech-language pathologist with expertise in treatment of communication disorders for patients with developmental disabilities to include:

- Documentation of speech disorder including limitations to effective communication
- Severity of speech deficit and functional limitations
- Rationale for the dedicated speech generating device recommended
- Documentation that alternative communication such as sign language, alphabet boards
- Patient's cognitive and functional ability to manage the device and level of interest to use the device
- Treatment plan indicating functional communication goals, with a plan of care for the device, training needs, and documented family/caregiver involvement in the use of the device

☐ Prescription for the requested device

☐ Invoice or quote of cost of Assistive Communication Device request

*Computers, tablets, computer programs/games used in association with communication aides, internet or phone services used in conjunction with communication devices are NOT covered.

_____
Provider Name

_____ _____
Provider Signature Date

FAX to: 888-974-5948 | Health Integrated, 10008 North Dale Mabry Hwy., Tampa, FL 33618 | **PHONE:** 888-211-6922