Prescription for Durable Medical Equipment

Patient's name: ____
Insurance ID#: ____
Address: ____

Diagnosis (with ICD-9 codes): __________________________________

Prognosis (ie chronic & stable, deteriorating, improving): ______________

Statement of Medical Necessity: _________________________________

Duration of Need: ____

Specific Equipment Needs:

I certify that I have reviewed, and concur with the therapist's recommendations, and that the requested equipment is reasonable and necessary for the treatment of the patient's expressive communication diagnosis, and is necessary to achieve the functional communication goals stated in the Speech-Language Pathologist's treatment plan.

______________________________	____________________
Physician's Original Signature	Date
______________________________	____________________
Physician's Printed Name	UPIN/Medicaid number
______________________________	____________________
Physician's Address	Telephone #
______________________________	