Recipient Attestation

For Continuing Use of Speech Generating Device (SGD)/Augmentative Communication Device (ACD)

This form is intended for provider type 33 (Durable Medical Equipment, Prosthetics, Orthotics and Supplies) to submit with other required documents, when appropriate, to confirm recipient compliance and appropriate equipment is being utilized.
Upload this request through the Provider Web Portal. For questions regarding this form, call: (800) 525-2395.

DATE OF REQUEST: _____/_____/_____

Note: The information provided on this form or on appropriate physician notes must be submitted with each prior authorization request for continuing recipient use of the device.

NOTES *(This space can be used for additional recipient comments)*:

RECIPIENT INFORMATION	
Recipient Name:	Date of Birth:
Recipient ID:	Phone:
SUPPLIER INFORMATION	
Supplier Name:	NPI:
Initial Authorization Number *(11-digits)*:	Phone:
Device Serial Number:	

RECIPIENT QUESTIONS

The following questions may be answered by the recipient, their spouse, their caregiver or their treating physician. The supplier must not provide answers to any question below.

1. **Are you the Medicaid recipient using the device?** ☐ **Yes** ☐ **No**
2. **In a 24-hour period, how many hours do you usually use this device?** _____ **Hours**
3. **What are the locations where you use this device?** _____
4. **About how many months have you been using this device?** _____ **Months**
5. **Do you think you are using this device successfully (without struggling)?** ☐ **Yes** ☐ **No**
6. **Do you think this device is the proper device for you?** ☐ **Yes** ☐ **No**
7. **What is the current condition of the device?** ☐ **New** ☐ **Used**
8. **Are there any areas with this device with which you need additional assistance?** ☐ **Yes** ☐ **No**
   If yes, please specify _____

Name of person who answered the above questions *(please print)*: _____

Relationship to recipient *(check one)*: ☐ **Self** ☐ **Caregiver** ☐ **Spouse** ☐ **Physician**

Signature: _____ **Date:** _____

Physician Name *(print)*: _____	
Physician Signature: _____	**Date:**

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.