**This completed form must be attached to all Speech Generating Device prior authorization (PA) requests. All information from the general prior authorization form can be entered when submitting the request via online portal (**[**http://myqualitrac.com**](http://myqualitrac.com)**). If choosing to submit the request via fax: Fax this completed form, a completed general PA form, all required documentation, and documentation of medical necessity to (866) 539-0365.**

**Date of Evaluation:**

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| Medicaid Participant Information | | | |
| Last Name: | First Name: | | |
| Medicaid ID: | | Date of Birth: | |
| Speech-Language Diagnosis & ICD Codes: | | | Date of Onset: |
| Anticipated Course of Impairment: | | | |

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| Speech-Language Pathologist Information | |
| Provider Name: | NPI: |
| Phone: | Fax: |

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| Summary of Current Skills | | | |
| **Summarize Development and Speech/Language Skills: (Attach ST Communication Evaluation. Include inventory of communication skills and sensory function.)** | | | |
| Current Communication Impairment:  Mild  Moderate  Severe | | | |
| Summarize: | | | |
| Physical, Cognitive, Hearing, and Vision Abilities and How They Affect the Use of the Requested Device: | | | |
| Summarize: | | | |
| Has Pt Had or Does Pt Have an SGD?  Yes  No | Date of Purchase: | | Length of Use: |
| Current/Previous SGD Make & Model: | | Aided  Unaided  Low-Tech  High-Tech | |
|  | |  | |
| Any Issues with the Current/Previous SGD:  Yes  No  Explain: | | | |
| Functional Benefit of Upgrade **OR** State “No SGD in the past”: | | | |
| Functional communication goals:  Gain attention of familiar & unfamiliar communication partners  Ask questions  Provide personal info to communication partners  Participate in medical appointments  Request personal ADL assistance  Request food, drink, object or action  Other: | | | |
| Why are you requesting an SGD?  Participant’s speaking needs cannot be met using natural communication methods or low-technology speaking devices.  Participant needs the ability to:  Express thoughts and ideas in emergency situations  Verbalize physical wants and needs to caregivers and family  Report to medical staff pain or other medical needs  Communicate with peers, family and others  Request object or actions  Other: | | | |
| What are the anticipated needs to warrant an SGD?  Ability to communicate physical needs and wants  Communicate with medical and educational staff  Socialize with family and caregivers  Improve expressive language  Participant is nonverbal and does not use speech to communicate. Traditional speech therapy techniques have  been unsuccessful. Is unable to convey the type and complexity of information she/he is capable of communicating  in daily interactions without a speech generating device.  Other: | | | |
| What features are needed or requested by this client/caregivers and justification for features? | | | |

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| Trial Information | |
| Trial documentation must include:  Minimum of three SGD trials from at least two different vendors.  Trial length of 1 week to 1 month for each device that may meet participant’s communication needs.  The amount of time the participant used the device each week. | |
| Device Trialed: | |
| Date Trial Started: | Duration of Trial: |
| Direct Select:  Eyes  Touch  Other: | |
| Scanning:  One Switch  Two Switch  Auditory  Visual | |
| Summary: | |
| Device Trialed: | |
| Date Trial Started: | Duration of Trial: |
| Direct Select:  Eyes  Touch  Other: | |
| Scanning:  One Switch  Two Switch  Auditory  Visual | |
| Summary: | |
| Device Trialed: | |
| Date Trial Started: | Duration of Trial: |
| Direct Select:  Eyes  Touch  Other: | |
| Scanning:  One Switch  Two Switch  Auditory  Visual | |
| Summary: | |

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| SGD Recommendation | |
| SGD Brand: | |
| Model Name: | Model Number: |
| The participant’s ability to meet daily communication needs will greatly benefit from acquisition & use of the device. | |
| Software Recommended: | |
| Accessories/Mounting: | |
| This combination of hardware, accessories, and software meets the communication needs of the participant because: | |

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| Support Team | |
| Please, list support team names and numbers (i.e. special education teacher, physical therapist, occupational therapist, school/private speech-language pathologist, habilitative interventionist, etc.). | |
| Name of Team Member & Role | Phone Number |
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| Who is responsible for programming, updating, and maintenance of the device? | |
| How has the patient’s IEP team, caregiver, physician, or other communication partners been included in this evaluation process? | |
| A copy of this report has been forwarded to the participants treating Physician prior to ordering device | |

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| Additional Required Documentation |
| Current speech/language reports including plan of care. |
| If applicable: Current Individualized Education Program (IEP). |
| If applicable: Letters documenting medical necessity. |

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| Acknowledgement |
| By signing below, I, the Speech/Language Pathologist performing this evaluation is not an employee of and does not have a financial relationship with the supplier of the speech generating device.  I agree to the information and recommendations in this report.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Speech-Language Pathologist’s Signature Phone Number Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physician or Non-Physician Practitioner’s Signature Phone Number Date |

* *The status of a prior authorization request may be checked via portal or by calling (866) 538-9510.*
* *Any questions regarding this process may be sent to* [*IDMedicaidsupport@telligen.com*](mailto:IDMedicaidsupport@telligen.com)*.*
* *More information is available at idmedicaid.com*