



SPEECH GENERATING DEVICE (DME) PRESCRIPTION

Date: _____

Patient Name: _____

Medicare/Insurance Number: _____

Diagnosis (w/code): _____

Prognosis: _____

Medical Necessity: (You may attach a separate document) _____

Length of Time: Months/Years _____

OR: Lifetime _____(provider's initials)

Write your order here: _____

OR Initial each component that you are prescribing

_____ (E2510) Eyegaze Edge Talker with Eyeworld Communication Software

_____ (E2599) Eyegaze Edge Eye Tracking Package

_____ (E2512) Eyegaze Edge Mounting Package

PHYSICIAN

Name (print): _____

Signature: _____ Date: _____

NPI: _____ License No: _____