nmotion®
Speech Solutions

GETTING STARTED

- Complete the customer intake packet. **All sections must be completed.**
- Provide a photo or scan of ***all*** insurance cards.
- The *Customer Information Checklist* MUST be signed and dated by the user. If the user cannot sign or is a minor, this form must be signed by a parent/guardian/spouse/POA. The checklist is a release of information and is needed for us to comply with HIPAA.
- The *Equipment Form* needs to be completed by the SLP or AT specialist. We need to know the make and model of the device being considered, as well as any accessories that may be recommended (such as mounts and or keyguards).
- If you require a free trial device, please let us know, and we can arrange to provide one.
- Check with your local consultant for the latest version of our report template as well as the report template resource guide to assist with the completion of your justification.

Intake Form

ORDER SET-UP

Sales Rep: _____

DEMOGRAPHICS

Device User Last Name: _____ Middle Initial: _____

Device User First Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Person: _____ Place of Service: Home

Facility: _____ Preferred Language: _____

Primary Phone: _____ Secondary Phone: _____

Cell Phone: _____ Fax: _____

Email address for client communication: _____

☐ Customer declined email ☐ Do not call for marketing ☐ Consent for marketing contact

Service Address (for delivery): _____

FUNDING

Primary: _____ Policy: _____ Group: _____

Secondary: _____ Policy: _____ Group: _____

Tertiary: _____ Policy: _____ Group: _____

☐ Self Pay ☐ Insurance Card was Requested

MEDICAL INFO

Dr. (prescribing): _____ Dr. Email: _____

Dr. Phone: _____ Dr. Fax: _____

Dr. Address: _____

Are you seeing or have you seen any specialists? (i.e. neurologist) ☐ Yes ☐ No

If yes, specialty: _____

Specialist Name: _____ Spec Email: _____

Spec Address: _____

Spec Phone: _____ Spec Fax: _____ Date of last visit: _____

SLP Name: _____ SLP Email: _____

SLP Phone: _____ SLP Fax: _____

SLP Company/School: _____ Date of last visit: _____

SLP Address: _____

Diagnosis: _____

CUSTOMER INFORMATION CHECKLIST

Customer Name: _____ **DOB:** _____

Equipment: _____

_____ **Mission, customer information, customer complaints, customer rights and responsibilies, and accreditation information (see Customer Handbook.)**

_____ **Acceptance of Services** - I understand by signing this agreement I authorize provision of products and/or services to me by Numotion. I also understand that the products and services provided are prescribed by my physician and that it is necessary that I remain under the supervision of my attending physician during the course of my care.

_____ **Medical Information Authorization** - I hereby authorize release to Numotion any, and all, of my medical records pertaining to my medical history, services rendered or treatments received from my physician(s), hospital or nursing agencies. In order to process insurance claims, I also hereby authorize Numotion to furnish to my insurance carriers, or school, any medical history, services rendered or treatment needed. I also understand that my information may be subject to review by credentialing, accreditation or governmental agencies.

_____ **Assignment of Insurance Benefits -** I authorize direct payment of insurance benefi ts by my insurance company to Numotion. In the event that my insurance carrier does not accept "assignment of benefits," I understand that payments may be sent directly to me and that I am obligated to endorse and directly send such payments to Numotion for payment of my bill. I understand that I am obligated to report any changes in insurance coverage promptly to Numotion.

_____ **Financial Responsibility -** I understand that I am responsible to Numotion for all charges not covered by my insurance. I recognize that in the event that my insurance company, employer or any other third party payor refuses to pay the rental and/or purchase price(s) of the above items, or delays payment beyond 90 days of my receipt of items, or in the event that I have no insurance coverage or third party payor, that I will be responsible for said payments and will make prompt reimbursement within 30 days of notification on by Numotion on for all charges.

_____ **If you have Medicaid -** I understand that if I have Medicaid I am not financially responsible for covered items as long as my Medicaid number is active at the time of delivery. I further understand that I may/will be responsible for charges if my Medicaid status changes. I will notify Numotion of any changes in my Medicaid coverage.

_____ **Return Policy -** The equipment Numotion sells is custom/specialized or ordered special and is not returnable. I authorize Numotion to send email order status updates to me, my caregiver and / or my clinician.

_____ **Photographic Release -** I hereby grant permission to Numotion to take photographs/video which may be used to document medical necessity for equipment or services provided by Numotion, and which may be submitted to insurance payors or other medical professionals as needed for evaluation on and/or consultation. I hereby release Numotion from any liability associated with these photographs/videos so long as they are used for the purposes as described above.

Print Name: _____

If not customer, relation to Customer: _____

Address: _____

Signature: _____ **Date:** _____

Numotion Representative: _____ **Date:** _____

Please call 888-546-8595 with any questions.

nmotion Speech Solutions

EQUIPMENT FORM

Device User Name: _____

FORBES AAC	ProSlate - ☐ 4 ☐ 8 ☐ 10		
Color	☐ ProSlate 4 onyx black ☐ ProSlate 4 candy pink ☐ ProSlate 4 electric blue ☐ ProSlate 4 frost white	☐ Proslate 8 arctic blue ☐ ProSlate 8 cotton white ☐ ProSlate 8 jet black ☐ ProSlate 8 taffy pink	☐ Proslate 10 bright pink ☐ ProSlate 10 sky blue ☐ ProSlate 10 rose gold ☐ ProSlate 10 coal black
App Choice			
Keyguard Needed (list size)			
Mount Plate Needed	☐ Yes	☐ No	
	☐ WinSlate 12 w/ Eyegaze ☐ WinSlate 12 w/out Eyegaze		
Keyguard Needed (list size)			
Mount Plate Needed	☐ Yes	☐ No	

LOGANTECH	LogansVoice ☐ 1 (7.9" iPad Mini) ☐ 3 (10.2" iPad) ☐ 7 (12.9" iPad Pro)			
Communication App				
Type of Case				
Voice Choice				
Keyguard (email screenshot)	☐ Yes ☐ No	# of Buttons		
Keyguard Setting Description				
	☐ ProxTalker Standard Touch ☐ ProxTalker Light Touch			
Tag Package	☐ 80 Pre-programmed Tags & 20 Blank Small Tags	☐ 100 Blank Small Tags		
Carry Solution	☐ Backpack - Blue	☐ Backpack - Black	☐ Backpack - Red	☐ Binder
Device Color	☐ Gray	☐ Blue	☐ Pink	
Voice Choice	☐ Juvenile Male	☐ Juvenile Female		
Tag Page Holders	☐ 4 Grey Velcro Set	☐ 4 Colored Page Set with Velcro		
	ProxPad Standard Package - 50 blank tags			
Need tactile cards? ☐ Yes ☐ No	Need Talking my Way cards (no voice)? ☐ Yes ☐ No	Need Ready Made Tangible Object cards? ☐ Yes ☐ No		
Additional Info				

nmotion Speech Solutions

EQUIPMENT FORM

Device User Name: _____

LINGRAPHICA

☐ Mini Talk 8 “	☐ Touch Talk 10”	☐ All Talk 12” (Laptop)

SMARTBOX DEVICES

Grid Pad ☐ 12” ☐ 15”		Eyegaze ☐ None ☐ Irisbond ☐ Alea	
Talk Pad (IOS) based table with grid for iPad ☐ 8” ☐ 10” ☐ 13”			
Touchpad 10” (Windows based tablet with Grid 3) ☐ No mountplate ☐ Dual mountplate			
Keyguard (email screenshot)	☐ Yes ☐ No	# of Buttons	
Keyguard Setting Description			

CONTROL BIONICS ☐ NueroNode Trilogy ☐ With Eyegaze ☐ Without Eyegaze

Is mount plate needed?	☐ Yes, dual mountplate	☐ Not needed

MOUNTS ☐ REHAdapt ☐ DAESSY ☐ Mount’n Mover

Floor Mount Needed ☐ Yes ☐ No	Wheelchair Mount Needed ☐ Yes ☐ No
Wheelchair Make & Model	

ACCESSORIES

Type of Switch	
Type of Mount Switch	
BJoy Ring	☐ Wired ☐ Wireless
Headmouse	☐ Origin Instruments Headmouse Nano ☐ Other: _____
Quha Zono 2	☐ Headband ☐ Head Mount Kit ☐ Eyewear Kit ☐ Eyeglass Clip ☐ Baseball Cap
Quha Sento (only comes with headband)	

Additional products recommended and notes:

nymotion®
Speech Solutions

Guidelines for Speech Generating Device

Your insurance may require the following:

Per Section 6407 of the Affordable Care Act, Medicare requires the Physician, PA, NP, or CNS to have a Face to Face (FTF) appointment/visit with the beneficiary for a communication evaluation. (Further evaluation may be referred to a licensed speech language pathologist.)

Medicare requires the Medical Record (Chart Notes) reflect that a FTF visit was performed. This FTF visit must be in the same format as all other Chart Notes.

Medicare does NOT accept letters of medical necessity as documentation of the FTF visit.

Medicare requires the following types of information relative to the prescription of a speech generating device:

1. History of present condition(s) and past medical history that is relevant to the patient's communication needs within the home environment.
2. Symptoms that limit communication.
3. Other diagnoses that may relate to communication problems.
4. Medications or other treatments and interventions for these diagnoses and symptoms. Progression of communication difficulty over time.

Contact us at 888-546-8595 if you have any questions, and we will be happy to assist you.