CSHCN Services Program Documentation of Receipt

This form must be kept in the client's file for *all* augmentative communication devices, durable medical equipment (DME), eyewear, orthotics and prosthetics, and prescription shoes. *Do not submit this form with your claim.*

For help completing this form, call the TMHP-CSHCN Services Program Contact Center at 1-512-514-3000, option 2, or 1-800-568-2413.

Please print or type requested information below.

Client Information:

First name:	Last name:
CSHCN Services Program number: 9-_____-00	Date of birth:
Address/City/State/ZIP:	
Diagnosis:	

Product Information:

Item	Number Received	Description (Include Model Number if Applicable)	Manufacturer's Serial Number (for DME only)

Certification:

I certify that on _____ (mm/dd/yyyy):

The client received the product as prescribed by the physician.

The product has been properly fitted to the client and meets the client's needs.

The client, the parent or guardian of the client, and any caregiver of the client has received training and instruction regarding the proper use and maintenance of the product.

Print or type receiver's name:	
Signature of client, parent or client representative:	Date:
Print or type supplier or provider name:	
Signature of supplier or provider:	Date:

THE RECEIVING PARTY AND THE SUPPLIER MUST SIGN AND DATE THIS FORM AT THE TIME THE PRODUCT IS ACTUALLY RECEIVED OR DELIVERED. THE DATE OF DELIVERY OF THE PRODUCT ON THIS FORM IS THE DATE OF SERVICE THAT SHOULD APPEAR ON THE CLAIM. PROVIDERS MUST MAINTAIN A COPY OF THIS FORM IN THEIR FILES FOR THE LIFE OF THE PRODUCT OR EQUIPMENT OR UNTIL IT IS AUTHORIZED FOR REPLACEMENT.