DLN _____ Medicaid ID _____ Individual Name _____

Authorization Request for Nursing Facility Specialized Services (NFSS)

NFSS for Durable Medical Equipment (DME)

Resident/NF

Resident Information

A0100A. First Name	A0100B. Middle Initial	A0100C. Last Name	A0100D. Suffix	A0200A. Social Security No.

A0200B. Medicare No.	A0300. Medicaid No.	A0400A. Birth Date	A0400B. Age at Time of Submission

Legally Authorized Representative (LAR) Information

A0500A. First Name	A0500B. Last Name

A0600A. Street Address	A0600B. City	A0600C. State	A0600D. ZIP Code

A0600E. Phone No.

Nursing Facility Information

A0700A. Provider No.	A0700B. Vendor No.	A0700C. NPI/API No.

A0700D. Facility Name	A0800A. Street Address	A0800B. City

A0800C. State	A0800D. ZIP Code	A0800E. County	A0900A. Phone No.	A0900B. Fax No.

LIDDA and LMHA Information

A1000A. LIDDA Provider No.	A1000B. LIDDA Vendor No.	A1000C. LIDDA NPI/API No.

A1100A. LMHA Provider No.	A1100B. LMHA Vendor No.	A1100C. LMHA NPI/API No.

Type of Service Requested

A2000. Request Type	Durable Medical Equipment
A2200. DME Service Type (Select only one)	☐ 1. DME Assessment Only 2. DME

DLN _____ Medicaid ID _____ Individual Name _____

A2210. Requested DME Item (Select all that apply)

- ☐ A. Gait Trainer
- ☐ B. Orthotic Device
- ☐ C. Positioning Wedge
- ☐ D. Prosthetic Device
- ☐ E. Special Needs Car Seat or Travel Restraint
- ☐ F. Specialized or Treated Pressure-Reducing Support Surface Mattress
- ☐ G. Standing Board/Frame

DLN _____ Medicaid ID _____ Individual Name _____

DME Assessment

Therapist Identifying Information

B0100A. First Name

B0100B. Last Name

B0200A. License Type (Select only one)

☐ 1. Occupational
☐ 2. Physical

B0200B. License No.

B0200C. License State

B0300. Is the Therapist employed by the Nursing Facility?

☐ 0. No
☐ 1. Yes

If the Therapist is not employed by the Nursing Facility complete the remainder of Therapist Identifying Information section.

B0400. Therapist's Employer Name

B0500A. Street Address

B0500B. City

B0500C. State

B0500D. ZIP Code

B0600A. Phone No.

B0600B. FAX No.

B0700. Therapist's Signature Date

To be entered from Attachment CMWC DME Signature Page.

Date of Assessment

B0800. Date of Assessment

Postural Control

B0900A. Head Control (Select one)

☐ 1. Good
☐ 2. Fair
☐ 3. Poor
☐ 4. None

B0900B. Trunk Control (Select one)

☐ 1. Good
☐ 2. Fair
☐ 3. Poor
☐ 4. None

B0900C. Upper Extremities (Select one)

☐ 1. Good
☐ 2. Fair
☐ 3. Poor
☐ 4. None

B0900D. Lower Extremities (Select one)

☐ 1. Good
☐ 2. Fair
☐ 3. Poor
☐ 4. None

Medical Surgical History and Plan

B1000A. Is there a history of decubitus/skin breakdown?

☐ 0. No
☐ 1. Yes

B1000B. If Yes, explain (minimum of 50 characters)

B1100A. Is there current decubitus/skin breakdown? ☐ 0. No 1. Yes

B1100B. If Yes, explain and include the wound stage and dimensions of each current site (minimum of 50 characters):

B1200. Describe orthopedic conditions and/or range of motion limitations requiring special consideration (e.g. contractures, degree of spinal curvature, etc.):

B1300. Describe other physical limitations or concerns (i.e., respiratory):

B1400. Describe any recent or expected changes in medical/physical/functional status:

B1500A. Is surgery anticipated? ☐ 0. No 1. Yes

B1500B. If Yes, indicate the expected date ☐

B1500C. If Yes, describe the procedure (minimum of 50 characters):

Neurological Factors

B1600A. Indicate resident's muscle tone (Select only one):

- ☐ 1. Absent
- 2. Fluctuating
- 3. Hypertonic
- 4. Other

B1600B. Describe resident's muscle tone (minimum of 50 characters):

B1600C. Describe active movements affected by muscle tone (minimum of 50 characters):

B1600D. Describe passive movements affected by muscle tone (minimum of 50 characters):

B1600E. Describe reflexes present (minimum of 50 characters):

Functional Assessment

B1700A. Ambulatory Status (Select only one):
1. Community ambulatory
2. Non-ambulatory
3. Short distances up to ___ feet
4. With assistance

B1700B. No. of feet

If Ambulatory Status is Short distance provide number of feet.

B1700C. Is the resident dependent upon a wheelchair or walker for ambulation?
0. No
1. Yes

B1700D. If Yes, describe the level of dependence. If no, describe the resident's ability to ambulate. (minimum of 50 characters)

B1800A. Indicate ambulation potential (Select only one):
1. Not expected
2. Expected within 1 year
3. Expected in the future

B1800B. No. of years (Select only one):
1. 1 year
2. 2 years
3. 3 years
4. 4 years
5. 5 years

If ambulation potential is expected in the future, enter the number of years.

DLN _____ Medicaid ID _____ Individual Name _____

B2000. Feeding (Select only one)
1. Maximum assistance
2. Moderate assistance
3. Minimum assistance
4. Independent

B2100A. Is the resident tube fed?
0. No
1. Yes

B2100B. If yes, explain (minimum of 50 characters)

B2200. Dressing (Select only one)
1. Maximum assistance
2. Moderate assistance
3. Minimum assistance
4. Independent

Educational/Vocational Setting

B2300A. Does the resident have a current education/vocational setting?
0. No
1. Yes

B2300B. If Yes, Name of educational/vocational site:

B2300C. If Yes, has the therapist from the educational/vocational setting been involved in this assessment?
0. No
1. Yes

B2310. Other Therapist from Education/ Vocational Setting

B2310A. First Name	B2310B. Last Name	B2310C. Phone No.

DLN _____ Medicaid ID _____ Individual Name _____

Referring Physician Identifying Information

To be completed by the Physician if Authorization Type is DME
Skip if Authorization Type is Assessment Only

B2400A. Last Name	B2400B. License State	B2400C. License No.	B2400D. Military Spec Code

B2400E. Date Resident Last Seen	B2400F. Signature Date	
		To be entered from the Attachment CMWC DME Signature Page

Note: The following Physician information is required if Physician is <u>not</u> licensed in Texas.

B2500. First Name

B2600A. Street Address

B2600B. City

B2600C. State

B2600D. ZIP Code

B2600E. Phone No.

Gait Trainer

Environment Assessment - Gait Trainer

D1000A. Is the resident's living environment accessible and safe for the use of the DME item requested?
☐ 0. No
1. Yes

D1000B. Will the DME item need to be transported?
☐ 0. No
1. Yes

D1000C. If Yes, describe how the DME item will be transported. (minimum of 50 characters)

If the resident does not have a current education/vocational setting skip to Supplier Information and MSRP Quote.
If the resident has a current education/vocational setting complete this section.

D1100A. Was a DME similar to the one requested used at this site?
☐ 0. No
1. Yes

D1100B. If Yes, is the site accessible and safe for the use of the DME item?
☐ 0. No
1. Yes

D1200. Additional comments and observations of educational/vocational therapist for this DME item:

Current DME Item - Gait Trainer

D1300. Does the resident have a current DME item or items? ☐ 0. No 1. Yes

If No, Skip to Requested DME Item - Gait Trainer.
If Yes, complete the following:

D1310. Describe the resident's current DME item(s) (if the item requested is a replacement), including the type and the age of the item. (minimum of 50 characters)

D1320. Describe why the current DME item(s) does/does not meet the resident's needs. (minimum of 50 characters)

DLN _____ Medicaid ID _____ Individual Name _____

Requested DME Item - Gait Trainer

D1400. Describe the DME item being requested (minimum of 50 characters):

D1410. Describe the medical necessity for the requested DME item (minimum of 50 characters):

D1420. Describe any anticipated modifications/changes to the requested DME item within the next five years (minimum of 50 characters):

D1430. Describe any equipment the resident must access on a regular basis and the effect, if any, this has on the use of the requested DME item (i.e., augmented communication device, wheelchair, other) (minimum of 50 characters):

Supplier Information and MSRP Quote

Supplier Information

D1500. Supplier's Business Name

D1510. Supplier's Representative Completing Form | D1510A. First Name | D1510B. Last Name

D1520A. Street Address | D1520B. City | D1520C. State | D1520D. ZIP Code

D1530A. Phone No. | D1530B. FAX No.

Itemized Manufacturer's Suggested Retail Price (MSRP) Quote

D1900B. Item No.	D1900C. HCPCS Code	D1900D. Description of Item	D1900E. Item Price*	D1900F. Quantity	D1900G. Total Price	D1900H. Approved Price
1					$	$
2					$	$
3					$	$
4					$	$
5					$	$
6					$	$
7					$	$
8					$	$

DLN _____ Medicaid ID _____ Individual Name _____

D1900B. Item No.	D1900C. HCPCS Code	D1900D. Description of Item	D1900E. Item Price*	D1900F. Quantity	D1900G. Total Price	D1900H. Approved Price
9					$	$
10					$	$
11					$	$
12					$	$
13					$	$
14					$	$
15					$	$
16					$	$
17					$	$
18					$	$
19					$	$
20					$	$
21					$	$
22					$	$
*Item Price must be based on MSRP.			D1900I. Total Amount of All Items Requested		1.$	2.$
			D1900J. Minus 18%		1.$	2.$
			D1900K. Grand Total		1.$	2.$

Receipt Certification

Upon receipt of a DME, the authorizing therapist must verify that the DME meets the needs of the individual and that the specifications are as intended in accordance with HHSC rules and policies.

Therapist Certification of Delivered Gait Trainer

By signing the Attachment CMWC/DME Receipt Certification, the therapist is certifying that the DME meets the needs of the individual and that the specifications are as intended in accordance with HHSC rules and policies. An attachment must be completed for each item requested and received.

D1600. Therapist's Name	A. First Name	B. Last Name
D1610. Therapist's License	A. License Type ☐ 1. Occupational 2. Physical	B. License No.
D1620. Therapist's Certification Date		

NF Administrator Certification of Delivered Gait Trainer

By signing the Attachment CMWC/DME Receipt Certification, the NF Administrator is attesting that the DME has been delivered as prescribed in the assessment to an individual who is a resident in the facility.

D1630. NF Administrator's Name	A. First Name	B. Last Name
D1640. Gait Trainer Received Date		
D1650. NF Administrator's Certification Date		

Orthotic Device

Environment Assessment - Orthotic Device

D2000A. Is the resident's living environment accessible and safe for the use of the DME item requested?

☐ 0. No
☐ 1. Yes

D2000B. Will the DME item need to be transported?

☐ 0. No
☐ 1. Yes

D2000C. If Yes, describe how the DME item will be transported. (minimum of 50 characters)

If the resident does not have a current education/vocational setting skip to Supplier Information and MSRP Quote.
If the resident has a current education/vocational setting complete this section.

D2100A. Was a DME similar to the one requested used at this site?

☐ 0. No
☐ 1. Yes

D2100B. If Yes, is the site accessible and safe for the use of the DME item?

☐ 0. No
☐ 1. Yes

D2200. Additional comments and observations of educational/vocational therapist for this DME item:

Current DME Item - Orthotic Device

D2300. Does the resident have a current DME item or items? ☐ 0. No ☐ 1. Yes

If No, Skip to Requested DME Item - Orthotic Device.
If Yes, complete the following:

D2310. Describe the resident's current DME item(s) (if the item requested is a replacement), including the type and the age of the item. (minimum of 50 characters)

D2320. Describe why the current DME item(s) does/does not meet the resident's needs. (minimum of 50 characters)

Requested DME Item - Orthotic Device

D2400. Describe the DME item being requested (minimum of 50 characters):

D2410. Describe the medical necessity for the requested DME item (minimum of 50 characters):

D2420. Describe any anticipated modifications/changes to the requested DME item within the next five years (minimum of 50 characters):

D2430. Describe any equipment the resident must access on a regular basis and the effect, if any, this has on the use of the requested DME item (i.e., augmented communication device, wheelchair, other) (minimum of 50 characters):

Supplier Information and MSRP Quote

Supplier Information

D2500. Supplier's Business Name

D2510. Supplier's Representative Completing Form | D2510A. First Name | D2510B. Last Name

D2520A. Street Address | D2520B. City | D2520C. State | D2520D. ZIP Code

D2530A. Phone No. | D2530B. FAX No.

Itemized Manufacturer's Suggested Retail Price (MSRP) Quote

D2900B. Item No.	D2900C. HCPCS Code	D2900D. Description of Item	D2900E. Item Price*	D2900F. Quantity	D2900G. Total Price	D2900H. Approved Price
1					$	$
2					$	$
3					$	$
4					$	$
5					$	$
6					$	$
7					$	$
8					$	$

DLN _____ Medicaid ID _____ Individual Name _____

D2900B. Item No.	D2900C. HCPCS Code	D2900D. Description of Item	D2900E. Item Price*	D2900F. Quantity	D2900G. Total Price	D2900H. Approved Price
9					$	$
10					$	$
11					$	$
12					$	$
13					$	$
14					$	$
15					$	$
16					$	$
17					$	$
18					$	$
19					$	$
20					$	$
21					$	$
22					$	$
*Item Price must be based on MSRP.			D2900I. Total Amount of All Items Requested		1.$	2.$
			D2900J. Minus 18%		1.$	2.$
			D2900K. Grand Total		1.$	2.$

DLN _____ Medicaid ID _____ Individual Name _____

Receipt Certification

Upon receipt of a DME, the authorizing therapist must verify that the DME meets the needs of the individual and that the specifications are as intended in accordance with HHSC rules and policies.

Therapist Certification of Delivered Orthotic Device

By signing the Attachment CMWC/DME Receipt Certification, the therapist is certifying that the DME meets the needs of the individual and that the specifications are as intended in accordance with HHSC rules and policies. An attachment must be completed for each item requested and received.

D2600. Therapist's Name	A. First Name	B. Last Name
D2610. Therapist's License	A. License Type ☐ 1. Occupational 2. Physical	B. License No.
D2620. Therapist's Certification Date		

NF Administrator Certification of Delivered Orthotic Device

By signing the Attachment CMWC/DME Receipt Certification, the NF Administrator is attesting that the DME has been delivered as prescribed in the assessment to an individual who is a resident in the facility.

D2630. NF Administrator's Name	A. First Name	B. Last Name
D2640. Orthotic Device Received Date		
D2650. NF Administrator's Certification Date		

DLN _____ Medicaid ID _____ Individual Name _____

Positioning Wedge

Environment Assessment - Positioning Wedge

D5000A. Is the resident's living environment accessible and safe for the use of the DME item requested?

☐ 0. No
☐ 1. Yes

D5000B. Will the DME item need to be transported?

☐ 0. No
☐ 1. Yes

D5000C. If Yes, describe how the DME item will be transported. (minimum of 50 characters)

If the resident does not have a current education/vocational setting skip to Supplier Information and MSRP Quote.
If the resident has a current education/vocational setting complete this section.

D5100A. Was a DME similar to the one requested used at this site?

☐ 0. No
☐ 1. Yes

D5100B. If Yes, is the site accessible and safe for the use of the DME item?

☐ 0. No
☐ 1. Yes

D5200. Additional comments and observations of educational/vocational therapist for this DME item:

DLN _____ Medicaid ID _____ Individual Name _____

Current DME Item - Positioning Wedge

D5300. Does the resident have a current DME item or items? ☐ 0. No ☐ 1. Yes

If No, Skip to Requested DME Item - Positioning Wedge.
If Yes, complete the following:

D5310. Describe the resident's current DME item(s) (if the item requested is a replacement), including the type and the age of the item. (minimum of 50 characters)

D5320. Describe why the current DME item(s) does/does not meet the resident's needs. (minimum of 50 characters)

Requested DME Item - Positioning Wedge

D5400. Describe the DME item being requested (minimum of 50 characters):

D5410. Describe the medical necessity for the requested DME item (minimum of 50 characters):

D5420. Describe any anticipated modifications/changes to the requested DME item within the next five years (minimum of 50 characters):

D5430. Describe any equipment the resident must access on a regular basis and the effect, if any, this has on the use of the requested DME item (i.e., augmented communication device, wheelchair, other) (minimum of 50 characters):

Supplier Information and MSRP Quote

Supplier Information

D5500. Supplier's Business Name

D5510. Supplier's Representative Completing Form | D5510A. First Name | D5510B. Last Name

D5520A. Street Address | D5520B. City | D5520C. State | D5520D. ZIP Code

D5530A. Phone No. | D5530B. FAX No.

Itemized Manufacturer's Suggested Retail Price (MSRP) Quote

D5900B. Item No.	D5900C. HCPCS Code	D5900D. Description of Item	D5900E. Item Price*	D5900F. Quantity	D5900G. Total Price	D5900H. Approved Price
1					$	$
2					$	$
3					$	$
4					$	$
5					$	$
6					$	$
7					$	$
8					$	$

DLN _____ Medicaid ID _____ Individual Name _____

D5900B. Item No.	D5900C. HCPCS Code	D5900D. Description of Item	D5900E. Item Price*	D5900F. Quantity	D5900G. Total Price	D5900H. Approved Price
9					$	$
10					$	$
11					$	$
12					$	$
13					$	$
14					$	$
15					$	$
16					$	$
17					$	$
18					$	$
19					$	$
20					$	$
21					$	$
22					$	$
*Item Price must be based on MSRP.			D5900I. Total Amount of All Items Requested		1.$	2.$
				D5900J. Minus 18%	1.$	2.$
				D5900K. Grand Total	1.$	2.$

DLN _____ Medicaid ID _____ Individual Name _____

Receipt Certification

Upon receipt of a DME, the authorizing therapist must verify that the DME meets the needs of the individual and that the specifications are as intended in accordance with HHSC rules and policies.

Therapist Certification of Delivered Positioning Wedge

By signing the Attachment CMWC/DME Receipt Certification, the therapist is certifying that the DME meets the needs of the individual and that the specifications are as intended in accordance with HHSC rules and policies. An attachment must be completed for each item requested and received.

D5600. Therapist's Name	A. First Name	B. Last Name
D5610. Therapist's License	A. License Type ☐ 1. Occupational 2. Physical	B. License No.
D5620. Therapist's Certification Date		

NF Administrator Certification of Delivered Positioning Wedge

By signing the Attachment CMWC/DME Receipt Certification, the NF Administrator is attesting that the DME has been delivered as prescribed in the assessment to an individual who is a resident in the facility.

D5630. NF Administrator's Name	A. First Name	B. Last Name
D5640. Positioning Wedge Received Date		
D5650. NF Administrator's Certification Date		

Prosthetic Device

Environment Assessment - Prosthetic Device

D6000A. Is the resident's living environment accessible and safe for the use of the DME item requested?

☐ 0. No
☐ 1. Yes

D6000B. Will the DME item need to be transported?

☐ 0. No
☐ 1. Yes

D6000C. If Yes, describe how the DME item will be transported. (minimum of 50 characters)

If the resident does not have a current education/vocational setting skip to Supplier Information and MSRP Quote.
If the resident has a current education/vocational setting complete this section.

D6100A. Was a DME similar to the one requested used at this site?

☐ 0. No
☐ 1. Yes

D6100B. If Yes, is the site accessible and safe for the use of the DME item?

☐ 0. No
☐ 1. Yes

D6200. Additional comments and observations of educational/vocational therapist for this DME item:

Current DME Item - Prosthetic Device

D6300. Does the resident have a current DME item or items?

☐ 0. No
☐ 1. Yes

If No, Skip to Requested DME Item - Prosthetic Device.
If Yes, complete the following:

D6310. Describe the resident's current DME item(s) (if the item requested is a replacement), including the type and the age of the item. (minimum of 50 characters)

D6320. Describe why the current DME item(s) does/does not meet the resident's needs. (minimum of 50 characters)

Requested DME Item - Prosthetic Device

D6400. Describe the DME item being requested (minimum of 50 characters):

D6410. Describe the medical necessity for the requested DME item (minimum of 50 characters):

D6420. Describe any anticipated modifications/changes to the requested DME item within the next five years (minimum of 50 characters):

D6430. Describe any equipment the resident must access on a regular basis and the effect, if any, this has on the use of the requested DME item (i.e., augmented communication device, wheelchair, other) (minimum of 50 characters):

Supplier Information and MSRP Quote

Supplier Information

D6500. Supplier's Business Name

D6510. Supplier's Representative Completing Form | D6510A. First Name | D6510B. Last Name

D6520A. Street Address | D6520B. City | D6520C. State | D6520D. ZIP Code

D6530A. Phone No. | D6530B. FAX No.

Itemized Manufacturer's Suggested Retail Price (MSRP) Quote

D6900B. Item No.	D6900C. HCPCS Code	D6900D. Description of Item	D6900E. Item Price*	D6900F. Quantity	D6900G. Total Price	D6900H. Approved Price
1					$	$
2					$	$
3					$	$
4					$	$
5					$	$
6					$	$
7					$	$
8					$	$

DLN _____ Medicaid ID _____ Individual Name _____

D6900B. Item No.	D6900C. HCPCS Code	D6900D. Description of Item	D6900E. Item Price*	D6900F. Quantity	D6900G. Total Price	D6900H. Approved Price
9					$	$
10					$	$
11					$	$
12					$	$
13					$	$
14					$	$
15					$	$
16					$	$
17					$	$
18					$	$
19					$	$
20					$	$
21					$	$
22					$	$
*Item Price must be based on MSRP.			D6900I. Total Amount of All Items Requested		1.$	2.$
				D6900J. Minus 18%	1.$	2.$
				D6900K. Grand Total	1.$	2.$

Receipt Certification

Upon receipt of a DME, the authorizing therapist must verify that the DME meets the needs of the individual and that the specifications are as intended in accordance with HHSC rules and policies.

Therapist Certification of Delivered Prosthetic Device

By signing the Attachment CMWC/DME Receipt Certification, the therapist is certifying that the DME meets the needs of the individual and that the specifications are as intended in accordance with HHSC rules and policies. An attachment must be completed for each item requested and received.

D6600. Therapist's Name	A. First Name	B. Last Name
D6610. Therapist's License	A. License Type ☐ 1. Occupational 2. Physical	B. License No.
D6620. Therapist's Certification Date		

NF Administrator Certification of Delivered Prosthetic Device

By signing the Attachment CMWC/DME Receipt Certification, the NF Administrator is attesting that the DME has been delivered as prescribed in the assessment to an individual who is a resident in the facility.

D6630. NF Administrator's Name	A. First Name	B. Last Name
D6640. Prosthetic Device Received Date		
D6650. NF Administrator's Certification Date		

Special Needs Car Seat or Travel Restraint

Environment Assessment - Special Needs Car Seat or Travel Restraint

D3000A. Is the resident's living environment accessible and safe for the use of the DME item requested?
☐ 0. No
☐ 1. Yes

D3000B. Will the DME item need to be transported?
☐ 0. No
☐ 1. Yes

D3000C. If Yes, describe how the DME item will be transported. (minimum of 50 characters)

If the resident does not have a current education/vocational setting skip to Supplier Information and MSRP Quote.
If the resident has a current education/vocational setting complete this section.

D3100A. Was a DME similar to the one requested used at this site?
☐ 0. No
☐ 1. Yes

D3100B. If Yes, is the site accessible and safe for the use of the DME item?
☐ 0. No
☐ 1. Yes

D3200. Additional comments and observations of educational/vocational therapist for this DME item:

Current DME Item - Special Needs Car Seat or Travel Restraint

D3300. Does the resident have a current DME item or items? ☐ 0. No 1. Yes

If No, Skip to Requested DME Item - Special Needs Car Seat or Travel Restraint.
If Yes, complete the following:

D3310. Describe the resident's current DME item(s) (if the item requested is a replacement), including the type and the age of the item. (minimum of 50 characters)

D3320. Describe why the current DME item(s) does/does not meet the resident's needs. (minimum of 50 characters)

Requested DME Item - Special Needs Car Seat or Travel Restraint

D3400. Describe the DME item being requested (minimum of 50 characters):

D3410. Describe the medical necessity for the requested DME item (minimum of 50 characters):

D3420. Describe any anticipated modifications/changes to the requested DME item within the next five years (minimum of 50 characters):

D3430. Describe any equipment the resident must access on a regular basis and the effect, if any, this has on the use of the requested DME item (i.e., augmented communication device, wheelchair, other) (minimum of 50 characters):

Supplier Information and MSRP Quote

Supplier Information

D3500. Supplier's Business Name

D3510. Supplier's Representative Completing Form | D3510A. First Name | D3510B. Last Name

D3520A. Street Address | D3520B. City | D3520C. State | D3520D. ZIP Code

D3530A. Phone No. | D3530B. FAX No.

Itemized Manufacturer's Suggested Retail Price (MSRP) Quote

D3900B. Item No.	D3900C. HCPCS Code	D3900D. Description of Item	D3900E. Item Price*	D3900F. Quantity	D3900G. Total Price	D3900H. Approved Price
1					$	$
2					$	$
3					$	$
4					$	$
5					$	$
6					$	$
7					$	$
8					$	$

DLN _____ Medicaid ID _____ Individual Name _____

D3900B. Item No.	D3900C. HCPCS Code	D3900D. Description of Item	D3900E. Item Price*	D3900F. Quantity	D3900G. Total Price	D3900H. Approved Price
9					$	$
10					$	$
11					$	$
12					$	$
13					$	$
14					$	$
15					$	$
16					$	$
17					$	$
18					$	$
19					$	$
20					$	$
21					$	$
22					$	$
*Item Price must be based on MSRP.			D3900I. Total Amount of All Items Requested		1.$	2.$
			D3900J. Minus 18%		1.$	2.$
			D3900K. Grand Total		1.$	2.$

DLN _____ Medicaid ID _____ Individual Name _____

Receipt Certification

Upon receipt of a DME, the authorizing therapist must verify that the DME meets the needs of the individual and that the specifications are as intended in accordance with HHSC rules and policies.

Therapist Certification of Delivered Special Needs Car Seat or Travel Restraint

By signing the Attachment CMWC/DME Receipt Certification, the therapist is certifying that the DME meets the needs of the individual and that the specifications are as intended in accordance with HHSC rules and policies. An attachment must be completed for each item requested and received.

D3600. Therapist's Name	A. First Name	B. Last Name
D3610. Therapist's License	A. License Type ☐ 1. Occupational 2. Physical	B. License No.
D3620. Therapist's Certification Date		

NF Administrator Certification of Delivered Special Needs Car Seat or Travel Restraint

By signing the Attachment CMWC/DME Receipt Certification, the NF Administrator is attesting that the DME has been delivered as prescribed in the assessment to an individual who is a resident in the facility.

D3630. NF Administrator's Name	A. First Name	B. Last Name
D3640. Special Needs Car Seat or Travel Restraint Received Date		
D3650. NF Administrator's Certification Date		

DLN _____ Medicaid ID _____ Individual Name _____

Specialized or Treated Pressure-Reducing Support Surface Mattress

Environment Assessment - Specialized or Treated Pressure-Reducing Support Surface Mattress

D4000A. Is the resident's living environment accessible and safe for the use of the DME item requested?
☐ 0. No
☐ 1. Yes

D4000B. Will the DME item need to be transported?
☐ 0. No
☐ 1. Yes

D4000C. If Yes, describe how the DME item will be transported. (minimum of 50 characters)

If the resident does not have a current education/vocational setting skip to Supplier Information and MSRP Quote.
If the resident has a current education/vocational setting complete this section.

D4100A. Was a DME similar to the one requested used at this site?
☐ 0. No
☐ 1. Yes

D4100B. If Yes, is the site accessible and safe for the use of the DME item?
☐ 0. No
☐ 1. Yes

D4200. Additional comments and observations of educational/vocational therapist for this DME item:

DLN _____ Medicaid ID _____ Individual Name _____

Current DME Item - Specialized or Treated Pressure-Reducing Support Surface Mattress

D4300. Does the resident have a current DME item or items? ☐ 0. No ☐ 1. Yes

If No, Skip to Requested DME Item - Specialized or Treated Pressure-Reducing Support Surface Mattress.
If Yes, complete the following:

D4310. Describe the resident's current DME item(s) (if the item requested is a replacement), including the type and the age of the item. (minimum of 50 characters)

D4320. Describe why the current DME item(s) does/does not meet the resident's needs. (minimum of 50 characters)

Requested DME Item - Specialized or Treated Pressure-Reducing Support Surface Mattress

D4400. Describe the DME item being requested (minimum of 50 characters):

D4410. Describe the medical necessity for the requested DME item (minimum of 50 characters):

D4420. Describe any anticipated modifications/changes to the requested DME item within the next five years (minimum of 50 characters):

DLN _____ Medicaid ID _____ Individual Name _____

D4430. Describe any equipment the resident must access on a regular basis and the effect, if any, this has on the use of the requested DME item (i.e., augmented communication device, wheelchair, other) (minimum of 50 characters):

Supplier Information and MSRP Quote

Supplier Information

D4500. Supplier's Business Name

D4510. Supplier's Representative Completing Form | D4510A. First Name | D4510B. Last Name

D4520A. Street Address | D4520B. City | D4520C. State | D4520D. ZIP Code

D4530A. Phone No. | D4530B. FAX No.

Itemized Manufacturer's Suggested Retail Price (MSRP) Quote

D4900B. Item No.	D4900C. HCPCS Code	D4900D. Description of Item	D4900E. Item Price*	D4900F. Quantity	D4900G. Total Price	D4900H. Approved Price
1					$	$
2					$	$
3					$	$
4					$	$
5					$	$
6					$	$
7					$	$
8					$	$

DLN _____ Medicaid ID _____ Individual Name _____

D4900B. Item No.	D4900C. HCPCS Code	D4900D. Description of Item	D4900E. Item Price*	D4900F. Quantity	D4900G. Total Price	D4900H. Approved Price
9					$	$
10					$	$
11					$	$
12					$	$
13					$	$
14					$	$
15					$	$
16					$	$
17					$	$
18					$	$
19					$	$
20					$	$
21					$	$
22					$	$
*Item Price must be based on MSRP.		D4900I. Total Amount of All Items Requested			1.$	2.$
		D4900J. Minus 18%			1.$	2.$
		D4900K. Grand Total			1.$	2.$

Receipt Certification

Upon receipt of a DME, the authorizing therapist must verify that the DME meets the needs of the individual and that the specifications are as intended in accordance with HHSC rules and policies.

Therapist Certification of Delivered Specialized or Treated Pressure-Reducing Support Surface Mattress

By signing the Attachment CMWC/DME Receipt Certification, the therapist is certifying that the DME meets the needs of the individual and that the specifications are as intended in accordance with HHSC rules and policies. An attachment must be completed for each item requested and received.

D4600. Therapist's Name	A. First Name	B. Last Name
D4610. Therapist's License	A. License Type ☐ 1. Occupational 2. Physical	B. License No.
D4620. Therapist's Certification Date		

NF Administrator Certification of Delivered Specialized or Treated Pressure-Reducing Support Surface Mattress

By signing the Attachment CMWC/DME Receipt Certification, the NF Administrator is attesting that the DME has been delivered as prescribed in the assessment to an individual who is a resident in the facility.

D4630. NF Administrator's Name	A. First Name	B. Last Name
D4640. Specialized or Treated Pressure-Reducing Support Surface Mattress Received Date		
D4650. NF Administrator's Certification Date		

DLN _____ Medicaid ID _____ Individual Name _____

Standing Board/Frame

Environment Assessment - Standing Board/Frame

D7000A. Is the resident's living environment accessible and safe for the use of the DME item requested?
☐ 0. No
☐ 1. Yes

D7000B. Will the DME item need to be transported?
☐ 0. No
☐ 1. Yes

D7000C. If Yes, describe how the DME item will be transported. (minimum of 50 characters)

If the resident does not have a current education/vocational setting skip to Supplier Information and MSRP Quote.
If the resident has a current education/vocational setting complete this section.

D7100A. Was a DME similar to the one requested used at this site?
☐ 0. No
☐ 1. Yes

D7100B. If Yes, is the site accessible and safe for the use of the DME item?
☐ 0. No
☐ 1. Yes

D7200. Additional comments and observations of educational/vocational therapist for this DME item:

Current DME Item - Standing Board/Frame

D7300. Does the resident have a current DME item or items? ☐ 0. No ☐ 1. Yes

If No, Skip to Requested DME Item - Standing Board/Frame.
If Yes, complete the following:

D7310. Describe the resident's current DME item(s) (if the item requested is a replacement), including the type and the age of the item. (minimum of 50 characters)

D7320. Describe why the current DME item(s) does/does not meet the resident's needs. (minimum of 50 characters)

DLN _____ Medicaid ID _____ Individual Name _____

Requested DME Item - Standing Board/Frame

D7400. Describe the DME item being requested (minimum of 50 characters):

D7410. Describe the medical necessity for the requested DME item (minimum of 50 characters):

D7420. Describe any anticipated modifications/changes to the requested DME item within the next five years (minimum of 50 characters):

DLN _____ Medicaid ID _____ Individual Name _____

D7430. Describe any equipment the resident must access on a regular basis and the effect, if any, this has on the use of the requested DME item (i.e., augmented communication device, wheelchair, other) (minimum of 50 characters):

Supplier Information and MSRP Quote

Supplier Information

D7500. Supplier's Business Name

D7510. Supplier's Representative Completing Form | D7510A. First Name | D7510B. Last Name

D7520A. Street Address | D7520B. City | D7520C. State | D7520D. ZIP Code

D7530A. Phone No. | D7530B. FAX No.

Itemized Manufacturer's Suggested Retail Price (MSRP) Quote

D7900B. Item No.	D7900C. HCPCS Code	D7900D. Description of Item	D7900E. Item Price*	D7900F. Quantity	D7900G. Total Price	D7900H. Approved Price
1					$	$
2					$	$
3					$	$
4					$	$
5					$	$
6					$	$
7					$	$
8					$	$

DLN _____ Medicaid ID _____ Individual Name _____

D7900B. Item No.	D7900C. HCPCS Code	D7900D. Description of Item	D7900E. Item Price*	D7900F. Quantity	D7900G. Total Price	D7900H. Approved Price
9					$	$
10					$	$
11					$	$
12					$	$
13					$	$
14					$	$
15					$	$
16					$	$
17					$	$
18					$	$
19					$	$
20					$	$
21					$	$
22					$	$
*Item Price must be based on MSRP.			D7900I. Total Amount of All Items Requested		1.$	2.$
			D7900J. Minus 18%		1.$	2.$
			D7900K. Grand Total		1.$	2.$

Receipt Certification

Upon receipt of a DME, the authorizing therapist must verify that the DME meets the needs of the individual and that the specifications are as intended in accordance with HHSC rules and policies.

Therapist Certification of Delivered Standing Board/Frame

By signing the Attachment CMWC/DME Receipt Certification, the therapist is certifying that the DME meets the needs of the individual and that the specifications are as intended in accordance with HHSC rules and policies. An attachment must be completed for each item requested and received.

D7600. Therapist's Name	A. First Name	B. Last Name
D7610. Therapist's License	A. License Type ☐ 1. Occupational 2. Physical	B. License No.
D7620. Therapist's Certification Date		

NF Administrator Certification of Delivered Standing Board/Frame

By signing the Attachment CMWC/DME Receipt Certification, the NF Administrator is attesting that the DME has been delivered as prescribed in the assessment to an individual who is a resident in the facility.

D7630. NF Administrator's Name	A. First Name	B. Last Name
D7640. Standing Board/Frame Received Date		
D7650. NF Administrator's Certification Date		