DME Certification and Receipt Form
Certificación y Recibo de Equipo Medico Duradero (DME)
(Page 1 of 4 - Required)

This certification is required by section 32.024 of the Human Resources Code and must be completed before the DME provider can be paid for durable medical equipment provided to a Medicaid client.

Esta certificación es necesaria bajo la Sección 32.024 del Código de Recursos Humanos y se debe Ilenar antes de poder rembolsar al proveedor del equipo médico duradero por cualquier equipo médico proporcionado al cliente de Medicaid.

Section A: Client Information			
Name*:	Medicaid ID Number*:		
Address:	City:	State:	ZIP:
Telephone Number:	Alternate Telephone Number:		

Section B: Provider Information		
Provider Name:	Prior Authorization Number (PAN):	
NPI/API:	Taxonomy:	Benefit Code:
Street Address:		
City:	State:	ZIP + 4:

Section C: Product Information		
Date of Service:		
Procedure Code:	Description:	Serial No:
Procedure Code:	Description:	Serial No:
Procedure Code:	Description:	Serial No:
Procedure Code:	Description:	Serial No:
Procedure Code:	Description:	Serial No:

Section D: Certification

This is to certify that on (month/day/year) _____ the client received the _____

(equipment) as prescribed by the physician. The equipment has been properly fitted to the client and/or meets the client's needs.

The client, parent, the guardian of the client, and/or caregiver of the client has received training and instruction regarding the equipment's proper use and maintenance.

_____ _____

Printed name of DME supplier | Printed name of client, parent, guardian, or primary caregiver

_____ _____

Signature of DME supplier | Signature of client, parent, guardian, or primary caregiver

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Section D: Certification

Certification (Spanish)

Esto certifica que el: (mes/día/año) _____ el cliente recibió [el] [la] [los] [las]

_____ (equipo) que el doctor recetó. El equipo ha sido adaptado correctamente para el cliente o satisface las necesidades del cliente.

El cliente, padre, o tutor, o el cuidador principal del cliente ha recibido entrenamiento e instrucción con respecto al uso y mantenimiento apropiado del equipo.

_____ _____

Nombre del proveedor del equipo médico duradero *Nombre del cliente, padre, tutor, o cuidador principal*

_____ _____

Firma del proveedor del equipo médico duradero *Firma del cliente, padre, tutor, o cuidador principal*

Section E: Qualified Rehabilitation Professional (QRP) Verification for Wheeled Mobility Systems

This is to certify that on (month/day/year) _____ the client received a wheeled mobility system or major modification to a wheeled mobility system as prescribed by the physician.

By signing this form, I verify all the following:

- I participated in the seating assessment for the wheeled mobility system or have obtained authorization to perform the fitting as the QRP, and
- The wheeled mobility system and/or major modification has been properly fitted to the client, and
- The wheeled mobility system and/or major modification meets the client's functional needs for seating, positioning, and mobility, and
- The client, parent, guardian of the client, and/or caregiver of the client has been trained and instructed regarding the wheeled mobility system's proper use and maintenance.

_____ _____

Printed name of QRP QRP NPI

_____ _____

Signature of QRP Date

This form must be submitted to TMHP for a single DME product with an allowed amount of $2500 or more, for multiple DME products submitted on the same date of service that meet or exceed a total billed amount of $2500, or for a wheeled mobility system or major modification of a wheeled mobility system. Section E must be completed for all wheeled mobility systems and major modifications to wheeled mobility systems. Submit this form with the appropriate claim form or fax this form to 512-506-6615. Information submitted in this form must match information in the claim form.

This form must be filled out completely; place none or N/A where applicable. Incomplete forms will be returned and will cause a delay in the verification and payment process. **Failure to submit this form will affect claim payment.**

Notice to clients: You may be contacted to verify receipt of the equipment provided.

Notificación al cliente: *Puede que usted sea contactado para verificar el recibo del equipo proporcionado.*

DME Certification and Receipt Form
Certificación y Recibo de Equipo Medico Duradero (DME)
(Page 3 of 4 - Required only for requests containing six or more items)

Client Information	
Medicaid ID Number*:	
Provider Information	
Provider Name*:	Prior Authorization Number (PAN):
NPI*/API:	

Product Information (Continuation)		
Date of Service:		
Procedure Code:	Description:	Serial No.:
Procedure Code:	Description:	Serial No.:
Procedure Code:	Description:	Serial No.:
Procedure Code:	Description:	Serial No.:
Procedure Code:	Description:	Serial No.:
Procedure Code:	Description:	Serial No.:
Procedure Code:	Description:	Serial No.:
Procedure Code:	Description:	Serial No.:
Procedure Code:	Description:	Serial No.:
Procedure Code:	Description:	Serial No.:

Certification

This is to certify that on (month/day/year) _____ the client received the _____ (equipment) as prescribed by the physician. The equipment has been properly fitted to the client and/or meets the client's needs.

The client, parent, the guardian of the client, and/or caregiver of the client has received training and instruction regarding the equipment's' proper use and maintenance.

_____ Printed name of DME supplier

_____ Printed name of client, parent, guardian, or primary caregiver

_____ Signature of DME supplier

_____ Signature of client, parent, guardian, or primary caregiver

Certification (Spanish)

Esto certifica que el: (mes/día/año) _____ el cliente recibió [el] [la] [los] [las]

_____ (equipo) que el doctor recetó. El equipo ha sido adaptado correctamente para el cliente o satisface las necesidades del cliente.

El cliente, padre, o tutor, o el cuidador principal del cliente ha recibido entrenamiento e instrucción con respecto al uso y mantenimiento apropiado del equipo.

_____ *Nombre del proveedor del equipo médico duradero*

_____ *Nombre del cliente, padre, tutor, o cuidador principal*

_____ *Firma del proveedor del equipo médico duradero*

_____ *Firma del cliente, padre, tutor, o cuidador principal*

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High Cost DME Call Verification

Your provider has sent you some medical equipment. We want to make sure that you got what you wanted and that it works well. We need to talk to you about the equipment before we can pay for it.

Call TMHP at 1-888-276-0702

Please call us toll-free at 1-888-276-0702 as soon as you can. We are open Monday through Friday from 7 a.m. to 7 p.m., Central Time. If you call us after hours, you can leave a message. Tell us your name, phone number, and the best time to call you back.

Required Information

Please have this information with you when you call:

- Name
- Medicaid number
- Birth date
- Address (street, city, state, ZIP)
- Provider's name
- Date you got the equipment
- Details about the equipment