OFFICE OF MEDICAL ASSISTANCE PROGRAMS

HOME HEALTH SERVICES

AUTHORIZATION FOR MEDICALLY NEEDY RECIPIENTS TO RECEIVE DURABLE MEDICAL EQUIPMENT AND/OR MEDICAL SUPPLIES

PATIENT'S RECIPIENT NUMBER

PATIENT'S NAME - Last Name - First - Middle Initial

☐ **DURABLE MEDICAL EQUIPMENT**
NAME OF ITEM(S)

☐ **MEDICAL SUPPLIES**
NAME OF ITEM(S)

PRESCRIBING PHYSICIAN'S NAME

DATE

I understand that my signature certifies that the need for the item(s) is necessary as part of the patient's plan of care.

SIGNATURE HHA REPRESENTATIVE

DATE

DPW COPY / FILE COPY