

# DURABLE MEDICAL EQUIPMENT REQUEST FOR NURSING FACILITY RESIDENT

NURSING FACILITY NAME:	SERVICE PROVIDER ID - SERVICE LOCATION NUMBERS:
AUTHORIZED REPRESENTATIVE:	AUTHORIZED REPRESENTATIVE ADDRESS:

The following checklist is to be used to assist you in submitting documentation for your Durable Medical Equipment (DME) request. Please attach these items, in the order listed, to the Outpatient Services Authorization Request (MA 97).

- This form, MA 97LTC, with the attestation portion completed, signed, and dated;
- A copy of the attending physician's prescription for the DME;
- The recipient's acknowledgement and/or consent, if possible;
- Current medical information of the client;
- If request is for a motorized wheelchair, include the original "Consideration for Motorized Wheelchair Prescription," and the wheelchair evaluation performed by a certified rehab facility stating what equipment is requested and what it will achieve for the resident;
- Procedure codes with MSRP pricing;
- List equipment tried and describe why it is not satisfactory to meet the resident's needs. Also, include documentation as to how services are provided currently and what alternatives are presently being employed;
- The most recent annual and quarterly MDS; and.
- Any other information that supports your request.

**Evidence that other forms of insurance have been exhausted, including HMO, managed care and Medicare will be required at the time the nursing facility bills the department.**

In your request for DME for your resident, you must sign the attestation and include all of the information listed above. Incomplete or missing information may result in processing delays of your request.

**Attestation:**

I attest that I have reviewed the attached Outpatient Services Authorization Request (MA 97) requesting authorization for DME for:

\_\_\_\_\_ ,a resident of  
 \_\_\_\_\_ (name of nursing facility)  
 \_\_\_\_\_ (provider number).

Admission Date: \_\_\_\_\_ Date of MA Eligibility: \_\_\_\_\_  
 Authorized staff of \_\_\_\_\_ (nursing facility) completed, or provided the information necessary to complete, fields 32 and 34 on the MA 97, and provided the related attachments. The DME supplier is not a related party as defined in Chapter 1187.2.

\_\_\_\_\_  
 NURSING HOME ADMINISTRATOR'S SIGNATURE DATE