Individual Name	Medicaid ID	DLN
	Medicaid ID	DLN

Authorization Request for Nursing Facility Specialized Services (NFSS) NFSS for Durable Medical Equipment (DME)

Resident/NF				
Resident Information				
A0100A. First Name A0100B. Middle Initi	ial A0100C. Last N	ame A	0100D. Suffix	A0200A. Social Security No.
A0200B. Medicare No. A0300. Medicaid No.	A0400A. Birth Da	te A0400B. Age	e at Time of Su	ıbmission
Legally Authorized Representative (LAR) Inform	ation			
A0500A. First Name	A	0500B. Last Name		Not to
A0600A. Street Address A0	0600B. City	<u> </u>	A0600C.	State A0600D. ZIP Code
De Faxe		the		iteor
A0600E. Phone No.				
Nursing Facility Information				
A0700A. Contract No. A0700B. Vendo	r No.	A0700C. NPI/API No.		
A0700D. Facility Name		A0800A. Street Addre	ess	A0800B. City
A0800C. State A0800D. ZIP Code A0800I	E. County	A0900A. Phone No.		A0900B. Fax No.
LIDDA and LMHA Information				
A1000A. LIDDA Contract No. A100	00B. LIDDA Vendor	No.	A1000C. LI	DDA NPI/API No.
A1100A. LMHA Contract No. A110	00B. LMHA Vendor	No.	A1100C. LI	MHA NPI/API No.
Type of Service Requested				
A2000. Request Type		le Medical Equipment		
A2200. DME Service Type (Select only one)		1. DME Assessment Only 2. DME		

	
A2210. Requested DME Item (Select all that apply)	
AZZTO. Requested DML Item (Select all triat apply)	
A. Gait Trainer	E. Special Needs Car Seat or Travel Restraint
B. Orthotic Device	F. Specialized or Treated Pressure-Reducing Support Surface Mattress
C. Positioning Wedge	G. Standing Board/Frame
D. Prosthetic Device	

Medicaid ID

For Reference Only, Not to be Faxed to the State or TMHP.

DLN	Medicaid ID	Individual Name

DME Assessment					
Therapist Identifying Information					
B0100A. First Name		B0100B. Last N	Name		
		J L			
B0200A. License Type (Select only one)	B0200B. License No.		B0200C. License St	tate	
1. Occupational 2. Physical					
B0300. Is the Therapist employed by the Nu	ırsing Facility?	0. No 1. Yes			
If the Therapist is not employed by the Nur.	sing Eacility complete t	ho romaindor of	Thorapist Idontifyir	a Information co	ection
in the merapist is not employed by the Nur	sing raciiity complete t	ine remainder of	merapist identifyii	ig illioithation se	ection.
B0400. Therapist's Employer Name					
B0500A. Street Address	B0500B. City	R050	OC. State	R05001	D. ZIP Code
BUSUUA. Street Address	B0300B. City	B030	oc. state	B03001	D. ZIF Code
B0600A. Phone No. B0600B. FAX N	lo. B0700. T	herapist's Signat	ture Date To be er	ntered from Attac	thment CMWC DME
			Signatur	re Page.	
Date of Assessment					
B0800. Date of Assessment					
Postural Control					
	Trunk Control		per Extremities	B0900D. Lowe	er Extremities
(Select one) (Select o		(Select one)	Cand	(Select one)	Cand
1. Good 2. Fair	1. Good 2. Fair	2.	Good Fair	2.	Good Fair
3. Poor 4. None	3. Poor 4. None		Poor None		Poor None
Medical Surgical History and Plan					
B1000A. Is there a history of decubitus/skin	ا (میریمامیییما). No I. Yes			
,		1. 163			

31000B. If Yes, explain (minimum of 50 characters)
Eor Reference On V-Not to
31100A. Is there current decubitus/skin breakdown? 1. Yes
31100B. If Yes, explain and include the wound stage and dimensions of each current site (minimum of 50 characters):
DE FAXEU LU LIIE STATE UI
TAALID
TMHP.
B1200. Describe orthopedic conditions and/or range of motion limitations requiring special consideration (e.g. contractures, degree of spinal curvature, etc.):

Medicaid ID

DLN	Medicaid ID	Individual Name
B1300. Describe ot	her physical limitations or concerns (i.e., respira	itory):
	Defense	Only Notto
	ny recent or expected changes in medical/physi	e univ. Noi io
be		the State or
		IIID
		IHP.
B1500A. Is surgery	anticipated? 0. No 1. Yes B1500B. If Y	es, indicate the expected date
B1500C. If Yes, des	cribe 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):
For Reference Only, Not to
be Faxed to the State or
B1600C. Describe active movements affected by muscle tone (minimum of 50 characters):
B1600D. Describe passive movements affected by muscle tone (minimum of 50 characters):

DLN

B1600E. Describe reflexes present (minimum of 50 characters):
Ear Deference Only Not to
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): 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
If ambulation potential is expected in the future, enter the number of years. 4. 4 years 5. 5 years 5. 5 years

Medicaid ID

DLN	Medicaid ID		Individual Name —	
B2000. Feeding (Select only one)	1. Maximum assis 2. Moderate assis 3. Minimum assis 4. Independent	tance		
B2100A. Is the resident tube fed?	0. No 1. Yes			
B2100B. If yes, explain (minimum	of 50 characters)			
For Re				lot to
be Fa	xed	to t	ne Stat	e or
B2200. Dressing (Select only one)	1. Maximum assis 2. Moderate assis 3. Minimum assis 4. Independent	stance	P.	
Educational/Vocational Setting				
B2300A. Does the resident have a	current education/voc	ational setting?	0. No 1. Yes	
B2300B. If Yes, Name of education	nal/vocational site:]		
B2300C. If Yes, has the therapist fr	om the educational/vo	cational setting beei	n involved in this assessment?	0. No 1. Yes
B2310. Other Therapist from Educ Vocational Setting	ation/ B2310A. F	irst Name	B2310B. Last Name	B2310C. Phone No.

Referring Physician Identifying	Information		
To be completed by the Physician Skip if Authorization Type is Asses			
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	n the Attachment CMWC DME Signature Page
Note: The following Physician inforr	nation is required if Physician is <u>n</u>	ot licensed in Texas.	
B2500. First Name	ferenc	e Onl	y, Not to
B2600A. Street Address		B2600I	3. City
he Fa	yed to	tha	State or
B2600C. State	B2600D. ZIP	Code	B2600E. Phone No.
		ШЪ	

Medicaid ID

DLN	Medicaid ID	Individual Name
Gait Trainer		
Environment Assessmen	nt - Gait Trainer	
D1000A. Is the resident's and safe for the use of the	living environment accessible 0. N e DME item requested? 1. Y	
D1000B. Will the DME iter	m need to be transported? 0. N	
D1000C. If Yes, describe h	ow the DME item will be transported. (m	inimum of 50 characters)
For F		e Only, Not to
be		the State or
	TN	HP.
	ave a current education/vocational settinn nt education/vocational setting complete	ng skip to Supplier Information and MSRP Quote. e this section.
D1100A. Was a DME simil	ar to the one requested used at this site?	0. No 1. Yes
D1100B. If Yes, is the site of DME item?	accessible and safe for the use of the	0. No 1. Yes
D1200. Additional comm	ents and observations of educational/voo	cational 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 (minimum of 50 characters)	a replacement), including the type and the age of the item.
For Reference	Only, Not to
be Faxed to t	he State or
D1320. Describe why the current DME item(s) does/does not meet the reside	ent's needs. (minimum of 50 characters)
	P.

D1410. Describe the medical necessity for the requested DME item (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):	DLN	Medicaid ID	Individual Name	
D1410. Describe the DME item being requested (minimum of 50 characters): D1410. Describe the medical necessity for the requested DME item (minimum of 50 characters):				
D1410. Describe the medical necessity for the requested DME item (minimum of 50 characters):	Requested DME Ite	m - Gait Trainer		
be Faxed to the State or TMHP.	D1400. Describe the	DME item being requested (minimum of 50 c	:haracters):	
be Faxed to the State or TMHP.				
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be Faxed to the State or TMHP.				
be Faxed to the State or TMHP.				
be Faxed to the State or TMHP.				
be Faxed to the State or TMHP.				-44
be Faxed to the State or TMHP.	FOR	Kererenc	le Uniy, No) [[[]] [] [] [] [] [] [] []
	D1410. Describe the	medical necessity for the requested DME iter	n (minimum of 50 characters):	
	be	raxed to	the State	or
D1420. Describe any anticipated modifications/changes to the requested DME item within the next five years (minimum of 50 characters):				
D1420. Describe any anticipated modifications/changes to the requested DME item within the next five years (minimum of 50 characters):				
D1420. Describe any anticipated modifications/changes to the requested DME item within the next five years (minimum of 50 characters):				
D1420. Describe any anticipated modifications/changes to the requested DME item within the next five years (minimum of 50 characters):				
	D1420. Describe any	anticipated modifications/changes to the red	quested DME item within the next five years (minii	mum of 50 characters):

DLN		Medicaid ID		Individual N	ame 			
		nent the resident must acco				s on the use of	the re	equested
Sunnlier I	nformation and I	MSRP Quote	nce ()nl		No	±	10
	nformation	wishi Quote						
	pplier's Business N	Name	toth	105	712			
D1510. Su	pplier's Represent	ative Completing Form	D1510A. First Name		D151	0B. Last Name		
D1520A. S	Street Address	D15	20B. City		D1520C. S	State [)1520	D. ZIP Code
D1530A. I	Phone No.	D1530B. FAX No.						
Itemized I	Manufacturer's S	uggested Retail Price (MS	SRP) Quote					
D1900B. Item No.	D1900C. HCPCS Code	D1900D. Descr	iption of Item	D1900E. Item Price*	D1900F. Quantity	D1900G. Total Price	Aı	D1900H. oproved Price
1						\$	\$	
2						\$	\$	
3						\$	\$	
4						\$	\$	
5						\$	\$	
6						\$	\$	
7						\$	\$	
0						٤	ا ج	

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		ererence u			\$	\$
16					\$	\$
17		axed to th			\$	\$
18					\$	\$
19					\$	\$
20					\$	\$
21					\$	\$
22					\$	\$
*Item Price	*Item Price must be based on MSRP. D1900I. Total Amount of All Items Requested 1.				1.\$	2.\$
D1900J. Minus 18% 1					1.\$	2.\$
		1.\$	2.\$			

Receipt Certification Upon receipt of a DME, the authorizing theral accordance with HHSC rules and policies.	pist must verify that the DME meets the nee	ds of the individual and that the specifications are as intended ir
	ipt Certification, the therapist is certifying th	nat the DME meets the needs of the individual and that the it 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	erence C	Inly, Not to
NF Administrator Certification of Deliv By signing the Attachment CMWC/DME Recei assessment to an individual who is a resident	ipt Certification, the NF Administrator is atte	esting that the DME has been delivered as prescribed in the
D1630. NF Administrator's Name	A. First Name	B. Last Name
D1640. Gait Trainer Received Date	TMH	
D1650. NF Administrator's Certification D	Pate	

Medicaid ID

DLN	Medicaid ID	Individual Name
Orthotic Devi	ce	
Environment Assessm	ent - Orthotic Device	
D2000A. Is the resident the use of the DME item	's living environment accessible and safe f n requested?	or 0. No 1. Yes
D2000B. Will the DME it	rem need to be transported?	0. No 1. Yes
D2000C. If Yes, describe	how the DME item will be transported. (n	ninimum of 50 characters)
		e Only, Not to the State or
If the resident does not	TA	ng skip to Supplier Information and MSRP Quote.
	nilar to the one requested used at this site	
D2100B. If Yes, is the sit item?	e accessible and safe for the use of the DM	AE 0. No 1. Yes
D2200. Additional com	ments and observations of educational/vo	cational therapist for this DME item:

Current DME Item - Orthotic Device D2300. Does the resident have a current DME item or items?	DLN	Medicaid ID	Individual Name
D2300. Does the resident have a current DME item or items? 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) For Reference Only, Not to be a complete the item.			
D2300. Does the resident have a current DME item or items? 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) For Reference Only, Notate Beginning the type and the age of the item.	Current DM	E 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) For Reference Only, Not to be Faxed to the State or	D2300. Does	the resident have a current DME item or items?	
For Reference Only, Not to be Faxed to the State or		•	
be Faxed to the State or			uested is a replacement), including the type and the age of the item.
be Faxed to the State or	E	r Referenc	o Only Not to
D2320. Describe why the current DME item(s) does/does not meet the resident's needs. (minimum of 50 characters)			the State or
	D2320. Desc	ribe 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	m - Orthotic Device		
D2400. Describe the	DME item being requested (minimum of 50	characters):	
-			
FOR	Kereren (ce Oniv, No i	
D2410. Describe the	medical necessity for the requested DME ite	em (minimum of 50 characters):	
	Eavod to	the State	
DE			
D2420. Describe any	anticipated modifications/changes to the re	equested DME item within the next five years (minimum o	of 50 characters):

DLN		Medicaid ID		Individual N	ame 		
		ent the resident must acce ommunication device, whe				s on the use of th	e requested
		ofore	nce) n l		No	
	nformation and M	ISRP Quote					
	nformation		to th				
	pplier's Business N						
D2510. Su	pplier's Representa	tive Completing Form	D2510A. First Name		D251	0B. Last Name	
D2520A. S	Street Address	D25	20B. City	D252	OC. State	D2	520D. ZIP Code
D2530A. I	Phone No.	D2530B. FAX No.					
		ggested Retail Price (MS	RP) Quote	_			
D2900B. Item No.	D2900C. HCPCS Code	D2900D. Descri	ption of Item	D2900E. Item Price*	D2900F. Quantity	D2900G. Total Price	D2900H. Approved Price
1						\$	\$
2						\$	\$
3						\$	\$
4						\$	\$
5						\$	\$
6						\$	\$
7						\$	\$
8						Ś	Ś

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		ererenced			\$	\$
16					\$	\$
17	ae I-	axed to th			\$	\$
18					\$	\$
19		TMH			\$	\$
20					\$	\$
21					\$	\$
22					\$	\$
*Item Price	*Item Price must be based on MSRP. D2900I. Total Amount of All Items Requested 1					2.\$
D2900J. Minus 18%1					1.\$	2.\$
		1.\$	2.\$			

DLN	Medicaid ID	Individual Name	_
Receipt Certification Upon receipt of a DME, the author accordance with HHSC rules and p		ME meets the needs of the individual and that the specifications a	are as intended ir
	DME Receipt Certification, the therap	oist is certifying that the DME meets the needs of the individual ar es. An attachment must be completed for each item requested a	
D2600. Therapist's Name	A. First Name	B. Last Name	
D2610. Therapist's License	A. License Type 1. Occupa 2. Physica		
D2620. Therapist's Certification	Date	a Only Not	to
		ministrator is attesting that the DME has been delivered as presci	ribed in the
D2630. NF Administrator's Nam	A. First Name	B. Last Name	H
D2640. Orthotic Device Receive	ed Date	ALP	
D2650. NF Administrator's Cert	ification Date		

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)
For Reference Only, Not to be Faxed to the State or Invited Brown of the State of Invited Brown of the State of Invited Brown of the 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

DLN	Medicaid ID	Individual Name
Current DME Item	- Positioning Wedge	
D5300. Does the res	sident have a current DME item or items?	0. No 1. Yes
If No, Skip to Reque If Yes, complete the	sted DME Item - Positioning Wedge. following:	
D5310. Describe the (minimum of 50 cha		quested is a replacement), including the type and the age of the item.
For		e Only, Not to
be	Faxed to	the State or
D5320. Describe wh	ny the current DME item(s) does/does not mee	et the resident's needs. (minimum of 50 characters)

Requested DME Item - Positioning Wedge D5400. Describe the DME item being requested (minimum of 50 characters):	
D5400. Describe the DME item being requested (minimum of 50 characters):	
For Keterence Univ. Not t	
D5410. Describe the medical necessity for the requested DME item (minimum of 50 characters):	
ho Fayod to the State or	\neg
De Layen to the State of	
TMHP	
D5420. Describe any anticipated modifications/changes to the requested DME item within the next five years (minimum of 50 char	cters).
bs 1261 bescribe any underpated modifications, changes to the requested binz item maint the rest interpated (minimum or 50 chair	

DLN		Medicaid ID		Individual N	ame 		
		ent the resident must acce ommunication device, whe				s on the use of th	ne requested
		efere	nce)nl		No	
	nformation and M nformation	ISKP Quote					
	pplier's Business N	ame	TO TE	105	7 6	oto /	OK
		ative Completing Form	D5510A. First Name		D551	0B. Last Name	
23310.34	ppiici s riepresente	ante completing room	FAALLI				
D5520A. S	Street Address	D55	20B. City	D55200	C. State	D5	520D. ZIP Code
D5530A. I	Phone No.	D5530B. FAX No.					
		uggested Retail Price (MS	RP) Quote				
D5900B. Item No.	D5900C. HCPCS Code	D5900D. Descri	ption of Item	D5900E. Item Price*	D5900F. Quantity	D5900G. Total Price	D5900H. Approved Price
1						\$	\$
2						\$	\$
3						\$	\$
4						\$	\$
5						\$	\$
6						\$	\$
7						\$	\$
8						Ś	s

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	TE B	Aference			\$	\$
16					\$	\$
17		byod to th			\$	\$
18		axea to ti			\$	\$
19		TAALI			\$	\$
20					\$	\$
21					\$	\$
22					\$	\$
*Item Price must be based on MSRP. D5900I. Total Amount of All Items Requested 1					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 authoriz accordance with HHSC rules and po		ME meets the needs of the individual and that the specifications are as intend	ded ir
	DME Receipt Certification, the therap	oist is certifying that the DME meets the needs of the individual and that the es. 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. Occupa 2. Physica		
D5620. Therapist's Certification I	Date	a Only Not to	7
NF Administrator Certification By signing the Attachment CMWC/I assessment to an individual who is a	OME Receipt Certification, the NF Ad	ge ministrator is attesting that the DME has been delivered as prescribed in the	
D5630. NF Administrator's Name	A. First Name	B. Last Name	
D5640. Positioning Wedge Rece	ived Date		
D5650. NF Administrator's Certif	ication 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)
For Reference Only, Not to be Faxed to the State or
TMID
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:

DLN

DLN	Medicaid ID	Individual Name
Current DME Item	- Prosthetic Device	
D6300. Does the re	sident have a current DME item or items?	0. No 1. Yes
If No, Skip to Reque If Yes, complete the	ested DME Item - Prosthetic Device. e following:	
D6310. Describe the		uested is a replacement), including the type and the age of the item.
For		e Only, Not to
be	Faxed to	the State or
D6320. Describe wh	ny the current DME item(s) does/does not meet	the resident's needs. (minimum of 50 characters)
	114	

DLN	Medicaid ID	Individual Name	
	Item - Prosthetic Device		
D6400. Describe t	the DME item being requested (minimum of 50 ch	naracters):	
Eor	Poforonc	a Only No	110
D6410 Describe t	the medical necessity for the requested DME item	(minimum of 50 characters):	440
06			or
D6420. Describe a	any anticipated modifications/changes to the req	uested DME item within the next five years (minimum	of 50 characters):

		ent the resident must accommunication device, wh				ns on the use of th	ne requested
	ar D	oforo) n l		No	+ + 0
Supplier I	nformation and M	ISRP Quote			7//	110	
	nformation						
D6500. Su	pplier's Business N	ame	TO U	ie :		ite	
 D6510. Տալ	pplier's Representa	itive Completing Form	D6510A. First Name		D651	0B. Last Name	
				D)			
D6520A. S	Street Address	D6	520B. City	D6520C	. State	D6	520D. ZIP Code
D6530A. F	Phone No.	D6530B. FAX No.					
		uggested Retail Price (M	SRP) Quote				
D6900B. Item No.	D6900C. HCPCS Code	D6900D. Desc	ription of Item	D6900E. Item Price*	D6900F. Quantity	D6900G. Total Price	D6900H. Approved Price
1						\$	\$
2						\$	\$
3						\$	\$
4						\$	\$
5						\$	\$
6						\$	\$
7						\$	\$

DLN

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		Aference			\$	\$
16					\$	\$
17		byod to th			\$	\$
18		aneu to ti			\$	\$
19		TAALI			\$	\$
20					\$	\$
21					\$	\$
22					\$	\$
*Item Price	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 th	erapist must verify that the DME meets the ne	eds of the individual and that the specifications are as intended in
accordance with HHSC rules and policies.		<u> </u>
	eceipt Certification, the therapist is certifying t	hat the DME meets the needs of the individual and that the nt 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	B. License No.
	1. Occupational 2. Physical	
D6620. Therapist's Certification Date	erence (nly, Not to
NF Administrator Certification of D By signing the Attachment CMWC/DME R assessment to an individual who is a resid	eceipt Certification, the NF Administrator is att	esting that the DME has been delivered as prescribed in the
D6630. NF Administrator's Name	A. First Name	B. Last Name
D6640. Prosthetic Device Received Da	ate	
D6650. NF Administrator's Certification	on Date	

Medicaid ID

Special Needs Car Seat or Travel Postraint	
Special Needs Car Seat or Travel Restraint Environment Assessment - Special Needs Car Seat or Travel Restrain	t
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. (minimu	m of 50 characters)
For Reference be Faxed to 1	
If the resident does not have a current education/vocational setting skip If the resident has a current education/vocational setting complete this s	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	al therapist for this DME item:

DLN

DLN	Medicaid ID	Individual Name
Current DME Item	n - Special Needs Car Seat or Travel Restrain	
D3300. Does the re	esident have a current DME item or items?	0. No 1. Yes
If No, Skip to Reque If Yes, complete th	ested DME Item - Special Needs Car Seat or Tra e following:	vel Restraint.
D3310. Describe th (minimum of 50 ch		quested is a replacement), including the type and the age of the item.
For		e Only, Not to
be	E Faxed to	the State or
D3320. Describe w	hy the current DME item(s) does/does not mee	et the resident's needs. (minimum of 50 characters)

DLN	Medicaid ID	Individual Name	
	ЛЕ Item - Special Needs Car Seat or Travel Restra		
D3400. Describ	oe the DME item being requested (minimum of 50 o	characters):	
	r kererend	e univ. Not	TO
D3410. Describ	be the medical necessity for the requested DME iter	m (minimum of 50 characters):	
6	e Faxed to	the State o	
			_
D3420. Describ	pe any anticipated modifications/changes to the re	equested DME item within the next five years (minimum of 50) characters):

			access on a regular basis ar wheelchair, other) (minimu			is on the use of th	e requested
Supplier I	nformation and I	MSRP Quote	ence (<u> </u>	<u>V,</u>	No	t to
Supplier I	nformation						
D3500. Su	pplier's Business N	lame	A LO LI	IE :		ILE	
D3510. Suլ	D3510. Supplier's Representative Completing Form D3510A. First Name D3510B. Last Name						
			TML	D)			
D3520A. S	Street Address	1	D3520B. City	D35200	. State	D3	520D. ZIP Code
D3530A. F	Phone No.	D3530B. FAX No.					
temized I	Manufacturer's S	uggested Retail Price	(MSRP) Quote				
D3900B. Item No.	D3900C. HCPCS Code	D3900D. De	escription of Item	D3900E. Item Price*	D3900F. Quantity	D3900G. Total Price	D3900H. Approved Price
1						\$	\$
2						\$	\$
3						\$	\$
4						\$	\$
5						\$	\$
6						\$	\$
7						\$	\$
0							

DLN

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		erence			\$	\$
16					\$	\$
17		axed to th			\$ [\$
18					\$	\$
19					\$	\$
20					\$	\$
21					\$	\$
22					\$	\$
*Item Price	e must be based o	n MSRP. D3900I. Total Amount	of All Items F	Requested	1.\$	2.\$
			D3900J. N	Minus 18%	1.\$	2.\$
D3900K. Grand Total				1.\$	2.\$	

DLN	Medicaid ID	Individual Name	
Receipt Certification Upon receipt of a DME, the author accordance with HHSC rules and p		NE meets the needs of the individual and that the specifications are as intended in	
By signing the Attachment CMWC		r Travel Restraint ist is certifying that the DME meets the needs of the individual and that the es. 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. Occupa 2. Physica		
D3620. Therapist's Certification	n Date	a Only Not to	
		r Seat or Travel Restraint ministrator is attesting that the DME has been delivered as prescribed in the	
D3630. NF Administrator's Nan	ne A. First Name	B. Last Name	
D3640. Special Needs Car Seat Restraint Received Date	or Travel		
D3650. NF Administrator's Cert	tification Date		

Specialized or Treated Pressure-Reducin	g Support Surface Mattress
Environment Assessment - Specialized or Treated Pressure-Reduce	
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. (minir	mum of 50 characters)
For Reference	e Only, Not to
be Faxed to	the State or
	HD
If the resident does not have a current education/vocational setting s If the resident has a current education/vocational setting complete th	·
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/vocation	onal therapist for this DME item:

Medicaid ID

DLN

DLN	Medicaid ID	Individual Name					
Current DME Item -	Specialized or Treated Pressure-Reducin	g Support Surface Mattress					
D4300. Does the resid	4300. Does the resident have a current DME item or items? 0. No 1. Yes						
If No, Skip to Request If Yes, complete the f	ted DME Item - Specialized or Treated Press following:	ure-Reducing Support Surface Mattress.					
D4310. Describe the (minimum of 50 char		equested is a replacement), including the type and the age of the item.					
For		ce Only, Not to					
be	Faxed to	the State or					
D4320. Describe why	the current DME item(s) does/does not me	et the resident's needs. (minimum of 50 characters)					

DLN	Medicaid ID	Individual Name	
	DME Item - Specialized or Treated Pressure-Reduci		
D4400. Des	ribe the DME item being requested (minimum of 50 c	haracters):	
	r Referenc	e Only, No i	
D4410. Des	ribe the medical necessity for the requested DME iten		
		the Ctete	
		the State	or
D4420. Des	ribe any anticipated modifications/changes to the rec	quested DME item within the next five years (minimum o	of 50 characters):
L			

		nent the resident must accommunication device, wh				is on the use of th	e requested
E	or R	efere	nce ()nl	V	Not	t to
Supplier I	nformation and I	MSRP Quote					
Supplier I	nformation						
D4500. Su	pplier's Business N	lame	TO H	le :		ite	
04510. Su	pplier's Representa	ative Completing Form	D4510A. First Name		D451	0B. Last Name	
D4520A. S	Street Address	D4	520B. City	D4520C	. State	D4	520D. ZIP Code
D4530A. F	Phone No.	D4530B. FAX No.					
temized I	Manufacturer's S	uggested Retail Price (M	SRP) Quote				
D4900B. Item No.	D4900C. HCPCS Code	D4900D. Desc	ription of Item	D4900E. Item Price*	D4900F. Quantity	D4900G. Total Price	D4900H. Approved Price
1						\$	\$
2						\$	\$
3						\$	\$
4						\$	\$
5						\$	\$
6						\$	\$
7						\$	\$
0						t	t

DLN

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		eterence L			\$	\$
16					\$	\$
17		axed to th			\$	\$
18					\$	\$
19					\$	\$
20					\$	\$
21					\$	\$
22					\$	\$
*Item Price	*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 thera accordance with HHSC rules and policies.	pist must verify that the DME meets the	needs of the individu	al and that the specificat	ions are as intended in
Therapist Certification of Delivered S By signing the Attachment CMWC/DME Recespecifications are as intended in accordance	eipt Certification, the therapist is certifyi	ng that the DME meets	s the needs of the individ	
D4600. Therapist's Name	A. First Name	B. Las	t Name	
D4610. Therapist's License	A. License Type 1. Occupational 2. Physical	B. Lice	ense No.	
D4620. Therapist's Certification Date	erence	Only	v, No	t to
NF Administrator Certification of Deli By signing the Attachment CMWC/DME Rece assessment to an individual who is a residen	eipt Certification, the NF Administrator i		-	
D4630. NF Administrator's Name	A. First Name	B. Las	t Name	
D4640. Specialized or Treated Pressure- Reducing Support Surface Mattress Received Date	TMH	P.		
D4650. NF Administrator's Certification	Date			

Medicaid ID

DLN

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)
For Reference Only, Not to be Faxed to the State or
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:

DLN

DLN	Medicaid ID	Individual Name
Current DME Ite	m - Standing Board/Frame	
	resident have a current DME item or items?	0. No 1. Yes
If No, Skip to Requ If Yes, complete t	uested DME Item - Standing Board/Frame. he following:	
D7310. Describe t (minimum of 50 c		quested is a replacement), including the type and the age of the item.
For		e Only, Not to
be	e Faxed to	the State or
D7320. Describe	why the current DME item(s) does/does not mee	t the resident's needs. (minimum of 50 characters)
		ІПР.

DLN	Medicaid ID	Individual Name
Requested DME I	Item - Standing Board/Frame	
	he DME item being requested (minimum of 50	characters):
	Reference	
D7410. Describe t	he medical necessity for the requested DME ite	
be		the State or
		1HP.
D7420. Describe a	any anticipated modifications/changes to the re	quested DME item within the next five years (minimum of 50 characters

			access on a regular basis ar wheelchair, other) (minimu			ns on the use of th	e requested
E	nformation and M	efere	ence (<u> Onl</u>	V ,	No	t to
	nformation	work Quote					
	pplier's Business N	lame	T to ti	TE :		ite	
		ative Completing Form	D7510A. First Name		D751	0B. Last Name	
				D			
D7520A. S	Street Address		D7520B. City	D75200	. State	D7	520D. ZIP Code
D7530A. F	Phone No.	D7530B. FAX No.					
		uggested Retail Price	(MSRP) Quote				
D7900B. Item No.	D7900C. HCPCS Code	D7900D. De	escription of Item	D7900E. Item Price*	D7900F. Quantity	D7900G. Total Price	D7900H. Approved Price
1						\$	\$
2						\$	\$
3						\$	\$
4						\$	\$
5						\$	\$
6						\$	\$
7						\$	\$

DLN

	DLN	Medicaid ID	Individual Name
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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		eterence		V,	\$	\$
16					\$	\$
17	oe H	axed to th			\$ [\$
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 accordance with HHSC rules and policies.	must verify that the DME meets the needs	of the individual and that the specifications are as intended in
Therapist Certification of Delivered Stand By signing the Attachment CMWC/DME Receipt	Certification, the therapist is certifying that	the DME meets the needs of the individual and that the 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	rence C	nly, Not to
NF Administrator Certification of Deliver By signing the Attachment CMWC/DME Receipt of assessment to an individual who is a resident in t	Certification, the NF Administrator is attest	ing that the DME has been delivered as prescribed in the
D7630. NF Administrator's Name	A. First Name	B. Last Name
D7640. Standing Board/Frame Received Date	TWEE	
D7650. NF Administrator's Certification Date		

Medicaid ID

DLN