MAP 95
(Rev. 6/07)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

REQUEST FOR EQUIPMENT FORM

RECIPIENTS NAME: _____ DOB: _____

MAID or MEMBER #: _____ DX: _____

Estimated Time Needed: Months _____ Indefinitely _____ Permanently _____
One Time Only_____

Procedure Code: _____ Date: _____

ITEM	ESTIMATE 1	ESTIMATE 2	ESTIMATE 3	TOTAL COST (includes shipping)

AGENCY NAME: _____

PROVIDER NUMBER: _____

CASE MANAGER/SUPPORT BROKER: _____

TELEPHONE NUMBER: _____

AUTHORIZED DMS SIGNATURE: _____

DATE APPROVED: _____

Print Form

Kentucky
UNBRIDLED SPIRIT