

MAP 95  
(Rev. 5/2010)

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

REQUEST FOR EQUIPMENT FORM

RECIPIENTS NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

MAID or MEMBER #: \_\_\_\_\_ DX: \_\_\_\_\_

ABI Waiver \_\_\_\_\_ ABI Long Term Care Waiver \_\_\_\_\_

Estimated Time Needed: Months \_\_\_\_\_ Indefinitely \_\_\_\_\_ Permanently \_\_\_\_\_  
One Time Only \_\_\_\_\_

Procedure Code: \_\_\_\_\_ Date: \_\_\_\_\_

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

AGENCY NAME: \_\_\_\_\_

PROVIDER NUMBER: \_\_\_\_\_

CASE MANAGER/SUPPORT BROKER: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

AUTHORIZED DMS SIGNATURE: \_\_\_\_\_

DATE APPROVED: \_\_\_\_\_

