

**COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES**

REQUEST FOR EQUIPMENT FORM

RECIPIENT'S NAME _____ MAID # _____ BIRTHDATE _____
Mo Day Yr

List Other Insurance Coverage _____

Estimated Time Needed # Months _____ Indefinitely _____ Permanently _____

Specific Equipment Item Requested: Please include Medicare codes for parts to items such as Braces, Prostheses, and Wheelchairs (if applicable). Otherwise, group parts together under Code E1399 or appropriate miscellaneous code for braces/prostheses.

PURCHASES:

ITEM	CODE	MANUFACTURER'S SUGGESTED LIST PRICE (IC ITEMS ONLY)	AGENCY'S ACQUISITION COST (ALL ITEMS)

Trade Name/Model Number of Equipment item (if applicable) _____

Manufacturer's Name _____

RENTAL:

If Rental is Requested, Please Specify Amount \$ _____

Supplier of Equipment _____

Address _____

Date of Delivery if Equipment Item is Already Place in Home – Date _____

Agency Name _____ Provider # _____

Authorized Signature _____ Date _____