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: _____

CLEAR