DLN Medicaid ID	Individual Name
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Authorization Request for Nursing Facility Specialized Services (NFSS) NFSS for Durable Medical Equipment (DME)

Resident/NF				
Resident Information				
A0100A. First Name A0100B. Midd	dle Initial A0100C. Last N	Name A0	100D. Suffix	A0200A. Social Security No.
A0200B. Medicare No. A0300. Medicai	d No. A0400A. Birth Da	ate A0400B. Age a	at Time of Subn	nission
Legally Authorized Representative (LAR)	Information			
A0500A. First Name	A	0500B. Last Name	y , I	Not to
A0600A. Street Address	A0600B. City	the S	A0600C. Sta	A0600D. ZIP Code
A0600E. Phone No.	TM	HP.		
Nursing Facility Information				
A0700A. Provider No. A0700B.	Vendor No.	A0700C. NPI/API No.		
A0700D. Facility Name		A0800A. Street Addres	S	A0800B. City
A0800C. State A0800D. ZIP Code	A0800E. County	A0900A. Phone No.	A0	900B. Fax No.
LIDDA and LMHA Information				
A1000A. LIDDA Provider No.	A1000B. LIDDA Vendor	No.	A1000C. LIDD	DA NPI/API No.
A1100A. LMHA Provider No.	A1100B. LMHA Vendor	No.	A1100C. LMH	A NPI/API No.
Type of Service Requested				
A2000. Request Type	Durab	ole Medical Equipment		
A2200. DME Service Type (Select only one)		1. DME Assessment Only 2. DME		

A2210. Requested DME Item (Select all that 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 Informa	tion		
B0100A. First Name		B0100B. Last Name	
BOTOOA.T IIST Name		Do Toob. East Name	
B0200A. License Type (Select or	nly one) B0200B. License No	o. B0200C. License	e State
1. Occupational 2. Physical			
B0300. Is the Therapist employe	ed by the Nursing Facility?	0. No 1. Yes	
If the Therapist is not employed	l by the Nursing Facility comple	te the remainder of Therapist Identif	fying Information section.
B0400. Therapist's Employer Na	ame	- 4b - C4	
B0500A. Street Address	B0500B. City	B0500C. State	B0500D. ZIP Code
B0600A. Phone No. B0	600B. FAX No. B0700		entered from Attachment CMWC DME eture Page.
Date of Assessment			
B0800. Date of Assessment			
Postural Control			
B0900A. Head Control (Select one)	B0900B. Trunk Control (Select one)	B0900C. Upper Extremities (Select one)	B0900D. Lower Extremities (Select one)
1. Good 2. Fair 3. Poor 4. None			
Medical Surgical History and	Plan		
B1000A. Is there a history of dec	cubitus/skin breakdown?	0. No 1. Yes	

B1000B. If Yes, explain (minimum of 50 characters)
B1100A. Is there current decubitus/skin breakdown? 0. No 1. Yes
1.163
B1100B. If Yes, explain and include the wound stage and dimensions of each current site (minimum of 50 characters):
TMHP.
I WITH.
B1200. Describe orthopedic conditions and/or range of motion limitations requiring special consideration (e.g. contractures, degree of
spinal curvature, etc.):

Medicaid ID

B1300. Describe other physical limitations or concerns (i.e., respiratory):
For Reference Only Not to
B1400. Describe any recent or expected changes in medical/physical/functional status:
be Faxed to the State or
TMHP.
B1500A. Is surgery anticipated? 0. No 1. Yes B1500B. If Yes, indicate the expected date
B1500C. If Yes, describe the procedure (minimum of 50 characters):

DLN

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
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): 1. Not expected 2. Expected within 1 year 3. Expected in the future
B1800B. No. of years (Select only one): If ambulation potential is expected in the future, enter the number of years. 1. 1 year 2. 2 years 3. 3 years 4. 4 years 5. 5 years

DLN

DLN	Medicaid ID 	Individual Name 	
B2000. Feeding (Select only one)	1. Maximum assistance 2. Moderate assistance 3. Minimum assistance 4. Independent		
B2100A. Is the resident tube fed?	0. No 1. Yes		
B2100B. If yes, explain (minimum o	f 50 characters)		
For Re	feren	ce Only, I	Not to
be Fa	xed to	o the Sta	te or
B2200. Dressing (Select only one)	1. Maximum assistance 2. Moderate assistance 3. Minimum assistance 4. Independent	ЛНР.	
Educational/Vocational Setting			
B2300A. Does the resident have a c	urrent education/vocational	setting? 0. No 1. Yes	
B2300B. If Yes, Name of education	al/vocational site:		
B2300C. If Yes, has the therapist fro	m the educational/vocationa	al setting been involved in this assessment?	0. No 1. Yes
B2310. Other Therapist from Educa Vocational Setting	tion/ B2310A. First Nan	me B2310B. Last Name	B2310C. Phone No.

Referring Physician Identifying In	formation			
To be completed by the Physician it Skip if Authorization Type is Assessi	Authorization Type is DME			
B2400A. Last Name	B2400B. License State	B2400C. License No.		B2400D. Military Spec Code
B2400E. Date Resident Last Seen	B2400F. Signature Date	To be entered fro	om the Attach	ment CMWC DME Signature Page
Note: The following Physician inform	ation is required if Physician is <u>n</u>	ot licensed in Texas.		
B2500. First Name	ferenc	e On	ly,	Not to
B2600A. Street Address		B260	0B. City	
be Fa	xed to	tha	STE	ate or
B2600C. State	B2600D. ZIP	Code	B2600E	. Phone No.

Medicaid ID

Gait Trainer
Environment Assessment - Gait Trainer
D1000A. Is the resident's living environment accessible and safe for the use of the DME item requested? 1. Yes
D1000B. Will the DME item need to be transported? 0. No 1. Yes
D1000C. 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
TMHP.
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.
D1100A. Was a DME similar to the one requested used at this site? 0. No 1. Yes
D1100B. If Yes, is the site accessible and safe for the use of the DME item? 0. No 1. Yes
D1200. Additional comments and observations of educational/vocational therapist for this DME item:

DLN

DLN	Medicaid ID	Individual Name
Current DME Item -	Gait Trainer	
D1300. Does the resi	dent have a current DME item or items?	0. No 1. Yes
If No, Skip to Reques If Yes, complete the	ted DME Item - Gait Trainer. following:	
D1310. Describe the (minimum of 50 chai		equested is a replacement), including the type and the age of the item.
For		e Only, Not to
be	Faxed to	the State or
D1320. Describe why	y the current DME item(s) does/does not me	et the resident's needs. (minimum of 50 characters)
		THP.

DLN	Medicaid ID	Individual Name	
Requested DME It	em - Gait Trainer		
D1400. Describe the	e DME item being requested (minimum of 50	characters):	
Eou			40
FOR	Reference	e Unity, NOT	10
D1410. Describe the	e medical necessity for the requested DME ite	em (minimum of 50 characters):	
l oe	Faxed to	o the State o	
D1420. Describe an	y anticipated modifications/changes to the re	equested DME item within the next five years (minimum of	50 characters):

			ess on a regular basis and eelchair, other) (minimum			as on the use of th	e requested
		<u>etere</u>	ncet	m	W_	Mai	
Supplier I	nformation and M	ASRP Quote					
Supplier I	nformation						
D1500. Su	ipplier's Business N	ame	toth	16 3		ate	
D1510. Su	pplier's Representa	tive Completing Form	D1510A. First Name		D151	0B. Last Name	
			TAALIE				
D1520A	Street Address	D11	520B. City		D1520C.:	State D1	520D. ZIP Code
D13207	Street Address		520b. City		D1320C.		JZOD. ZII COUC
D1530A. I	Phone No.	D1530B. FAX No.					
Itemized I	Manufacturer's Su	ıggested Retail Price (M	SRP) Quote				
D1900B.	D1900C. HCPCS	D1900D. Desci		D1900E.	D1900F.	D1900G.	D1900H.
Item No.	Code	D 1700D. D CSC	mption of item	Item Price*	Quantity	Total Price	Approved Price
1						\$	\$
2						\$	\$
3						\$	\$
4						\$	\$
5						\$	\$
6						\$	\$
7						\$	\$
8						s	\$

DLN

DLN Medicaid ID Individual Name	
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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		ererenced		V,	\$	\$
16					\$	\$
17		axed to th			\$ [\$
18					\$	\$
19		TMHI			\$	\$
20					\$	\$
21					\$	\$
22					\$	\$
*Item Price must be based on MSRP. D1900I. Total Amount of All Items Requested 1					1.\$	2.\$
			D1900J. I	Minus 18%	1.\$	2.\$
			D1900K. G	rand Total	1.\$	2.\$

Receipt Certification Upon receipt of a DME, the authorizing therapaccordance 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
	pt Certification, the therapist is certifying th	nat the DME meets the needs of the individual and that the intuit 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	pt 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	ate	

Medicaid ID

Orthotic Device
Environment Assessment - Orthotic Device
D2000A. Is the resident's living environment accessible and safe for the use of the DME item requested? 0. No 1. Yes
D2000B. Will the DME item need to be transported? 0. No 1. Yes
D2000C. 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.
D2100A. Was a DME similar to the one requested used at this site? 0. No 1. Yes
D2100B. If Yes, is the site accessible and safe for the use of the DME item? 0. No 1. Yes
D2200. Additional comments and observations of educational/vocational therapist for this DME item:

DLN

DLN	Medicaid ID	Individual Name
Current DME Iter	m - Orthotic Device	
D2300. Does the r	resident have a current DME item or items?	0. No 1. Yes
If No, Skip to Requ If Yes, complete th	uested DME Item - Orthotic Device. he following:	
D2310. Describe t (minimum of 50 c		uested is a replacement), including the type and the age of the item.
For		e Only, Not to
be	e Faxed to	the State or
D2320. Describe v	why the current DME item(s) does/does not meet	t the resident's needs. (minimum of 50 characters)

Medicaid ID	Individual Name	
Orthotic Device		
	characters):	
adical recession for the requested DNAT in	en (minimum of 50 share stars):	
edical necessity for the requested DME Ite	em (minimum of 50 characters):	7
ticipated modifications/changes to the re	equested DME item within the next five years (minimum of 50 characte	 ≥rs):
	edical necessity for the requested DME ite	Orthotic Device It item being requested (minimum of 50 characters): Edical necessity for the requested DME item (minimum of 50 characters): Edical necessity for the requested DME item (minimum of 50 characters): Edical necessity for the requested DME item (minimum of 50 characters): Edical necessity for the requested DME item within the next five years (minimum of 50 characters):

				-			
			ccess on a regular basis ar vheelchair, other) (minimu			s on the use of th	e requested
	D.	of our				Mad	
Supplier I	nformation and M	ASRP Quote	-111				
Supplier I	nformation						
D2500. Su	pplier's Business N	lame	I to th	105	YE	Te (or
D2510. Su	pplier's Representa	ative Completing Form	D2510A. First Name		D2510	OB. Last Name	
			TAALL	D			
D2520A. S	Street Address	D	2520B. City	D252	20C. State	D2	520D. ZIP Code
D2530A. I	Phone No.	D2530B. FAX No.					
 Itemized	Manufacturer's Su	uggested Retail Price (MSRP) Quote				
D2900B. Item No.	D2900C. HCPCS Code		scription of Item	D2900E. Item Price*	D2900F.	D2900G. Total Price	D2900H.
	Code			Item Filce	Quantity		Approved Price
1						\$	\$
2						\$	\$
3						\$	\$
4						\$	\$
5						\$	\$
6						\$	\$
7						\$	\$
8						\$	\$

DLN

DLN	Medicaid ID	Individual Name	
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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	DIFE	ererenced		V.	\$	\$
16					\$	\$
17		axed to th			\$	\$
18					\$	\$
19		TMHI			\$	\$
20					\$	\$
21					\$	\$
22					\$	\$
*Item Price must be based on MSRP. D2900I. Total Amount of All Items Requested					1.\$	2.\$
			D2900J. I	Minus 18%	1.\$	2.\$
			D2900K. G	rand Total	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 are as intend	ded ir
	C/DME Receipt Certification, the therap	pist is certifying that the DME meets the needs of the individual and that the ies. An attachment must be completed for each item requested and received	
D2600. Therapist's Name	A. First Name	B. Last Name	
D2610. Therapist's License	A. License Type 1. Occup 2. Physica	l l	
D2620. Therapist's Certification	n Date	a Only Not to	7
		dministrator is attesting that the DME has been delivered as prescribed in the	
D2630. NF Administrator's Nan	ne A. First Name	B. Last Name	
D2640. Orthotic Device Receiv	ed Date		
D2650. NF Administrator's Cert	tification Date		

Positioning Wedge
nvironment Assessment - Positioning Wedge
5000A. Is the resident's living environment accessible and safe for ne use of the DME item requested? 0. No 1. Yes
5000B. Will the DME item need to be transported? 0. No 1. Yes
5000C. 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
the resident does not have a current education/vocational setting skip to Supplier Information and MSRP Quote. the resident has a current education/vocational setting complete this section. 5100A. Was a DME similar to the one requested used at this site? 0. No 1. Yes
5100B. If Yes, is the site accessible and safe for the use of the DME 0. No 1. Yes
5200. Additional comments and observations of educational/vocational therapist for this DME item:

Medicaid ID

DLN	Medicaid ID	Individual Name
Current DME Item	- Positioning Wedge	
D5300. 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 - Positioning Wedge. e following:	
D5310. Describe the (minimum of 50 ch		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 wl	ny the current DME item(s) does/does not mee	et the resident's needs. (minimum of 50 characters)
D5320. Describe wh		

DLN	Medicaid ID	Individual Name
Requested DME Ite	m - Positioning Wedge	
D5400. Describe the	DME item being requested (minimum of 50	characters):
For	Reference	e Only, Not to
D5410. Describe the	medical necessity for the requested DME ite	em (minimum of 50 characters):
be	Faxed to	o the State or
		AHP.
D5420. Describe any	anticipated modifications/changes to the re	equested DME item within the next five years (minimum of 50 characters):

				_			
			ccess on a regular basis a vheelchair, other) (minim			s on the use of th	ne requested
	or B	oforc	ance (Nat	
Supplier I	nformation and M	ISRP Quote					
Supplier I	nformation						
D5500. Su	pplier's Business N	ame	I to th	ne	Site	Ite	
D5510. Su	pplier's Representa	tive Completing Form	D5510A. First Name		D5510	OB. Last Name	
			TAALL				
D5520A. S	Street Address	D	5520B. City	D5520	C. State	D5	520D. ZIP Code
D5530A. I	Phone No.	D5530B. FAX No.					
		ggested Retail Price (I	MSRP) Quote				
D5900B. Item No.	D5900C. HCPCS Code	D5900D. Des	scription of Item	D5900E. Item Price*	D5900F. Quantity	D5900G. Total Price	D5900H. Approved Price
1						\$	\$
2						\$	\$
3						\$	\$
4						\$	\$
5						\$	\$
6						\$	\$
7						\$	\$
8						\$	\$

DLN

DLN	Medicaid ID	Individual Name	
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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		aference (\$	\$
16					\$	\$
17		byod to th			\$	\$
18		antu 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%						2.\$
			D5900K. G	rand Total	1.\$	2.\$

DLN	Medicaid ID	Individual Name ————————————————————————————————————
Receipt Certification Upon receipt of a DME, the authori accordance with HHSC rules and p		ME meets the needs of the individual and that the specifications are as intende
Therapist Certification of Del By signing the Attachment CMWC/ specifications are as intended in ac	/DME Receipt Certification, the therap	pist is certifying that the DME meets the needs of the individual and that the ies. 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. Occup 2. Physica	I I
D5620. Therapist's Certification	Date	a Only Not to
		lge dministrator is attesting that the DME has been delivered as prescribed in the
D5630. NF Administrator's Nam	A. First Name	B. Last Name
D5640. Positioning Wedge Reco	eived Date	
D5650. NF Administrator's Cert	ification 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
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

Current DME Item - Prosthetic Device
D6300. Does the resident have a current DME item or items? 0. No 1. Yes
If No, Skip to Requested DME Item - Prosthetic Device. If Yes, complete the following:
D6310. 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
D6320. Describe why the current DME item(s) does/does not meet the resident's needs. (minimum of 50 characters)

Medicaid ID

Requested DME Item - Prosthetic Device	
D6400. Describe the DME item being requested (minimum of 50 characters):	
Ear Deference Only Not	
FOI REIEIGHLE VIIIY, NOL	
D6410. Describe the medical necessity for the requested DME item (minimum of 50 characters):	
be Faxed to the State o	
be laked to the state o	
IMHP	
D6420. Describe any anticipated modifications/changes to the requested DME item within the next five years (minimum of 50 minimum).	characters):

			nt access on a regular ba e, wheelchair, other) (m				s on the use of th	e requested
E	or Ro	efer	ence)nl	V,	No:	tto
Supplier I	nformation and M	SRP Quote						
Supplier I	nformation							
D6500. Su	pplier's Business Na	ame	u to				ILE	
D6510. Տսլ	pplier's Representa	tive Completing For	m D6510A. First N	lame		D651	0B. Last Name	
			TIME					
D6520A. S	Street Address		D6520B. City		D6520C	. State	D6	520D. ZIP Code
D6530A. F	Phone No.	D6530B. FAX No).					
Itemized I		ggested Retail Pric	e (MSRP) Quote					
D6900B. Item No.	D6900C. HCPCS Code	D6900D. I	Description of Item		D6900E. Item Price*	D6900F. Quantity	D6900G. Total Price	D6900H. Approved Price
1							\$	\$
2							\$	\$
3							\$	\$
4							\$	\$
5							\$	\$
6							\$	\$
7							\$	\$
8							\$	\$

Medicaid ID

DLN	Medicaid ID	Individual Name	
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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	THE R	Aference			\$	\$
16					\$	\$
17		byod to th			\$	\$
18		aneu to ti			\$	\$
19		TAALI			\$	\$
20					\$	\$
21					\$	\$
22					\$	\$
*Item Price must be based on MSRP. D6900I. Total Amount of All Items Requested				Requested	1.\$	2.\$
D6900J. Minus 18%				1.\$	2.\$	
D6900K. Grand Total 1.				1.\$	2.\$	

Receipt Certification Upon receipt of a DME, the authorizing therapis accordance with HHSC rules and policies.	t must verify that the DME meets the ne	eds of the i	ndividual and that the specifications are as intended in		
	Certification, the therapist is certifying		IE meets the needs of the individual and that the completed for each item requested and received.		
D6600. Therapist's Name	A. First Name		B. Last Name		
2 social metapists raine					
D6610. Therapist's License	A. License Type		B. License No.		
	1. Occupational 2. Physical				
D6620. Therapist's Certification Date	rence (d			
NF Administrator Certification of Delive By signing the Attachment CMWC/DME Receipt assessment to an individual who is a resident in	Certification, the NF Administrator is at	testing 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 Date	TMH	B .			
D6650. NF Administrator's Certification Dat	re				

Medicaid ID

Special Needs Car Seat or Travel Restraint	
Environment Assessment - Special Needs Car Seat or Travel Restraint	= 0 No
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. (minimum	of 50 characters)
For Reference be Faxed to t	
TAIL	
If the resident does not have a current education/vocational setting skip to If the resident has a current education/vocational setting complete this second	• •
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 t	nerapist for this DME item:

Medicaid ID

DLN	Medicaid ID	Individual Name			
Current DME Item -	Special Needs Car Seat or Travel Restraint				
D3300. Does the resi	0. No 1. Yes				
If No, Skip to Request If Yes, complete the f	ted DME Item - Special Needs Car Seat or Tra following:	vel Restraint.			
D3310. Describe the (minimum of 50 char		quested is a replacement), including the type and the	e age of the item.		
For be	Reference Faxed to	e Only, No	ot to or		
D3320. Describe why	the current DME item(s) does/does not mee	et the resident's needs. (minimum of 50 characters)			

DLN	Medicaid ID	Individual Name
	d DME Item - Special Needs Car Seat or Travel Restrai	
D3400. De	scribe the DME item being requested (minimum of 50 cl	naracters):
	or Referenc	e Only, Not to
D3410. De	scribe the medical necessity for the requested DME item	(minimum of 50 characters):
	- F d 4-	1 - C1 - 1
		the State or
		IHP.
D3420 De	scribe any anticipated modifications/changes to the reg	uested DME item within the next five years (minimum of 50 characters):
D3420. DC	scribe any anticipated mounications, changes to the req	desica DME Item within the flext five years (minimum of 30 characters).

				_			
		ent the resident must acc mmunication device, wh				s on the use of th	ne requested
							440
Samuel and			nce t		Y /	110	
	nformation and M nformation	ISKP Quote					
	pplier's Business Na	ame	TO L	Te :	Dic	ite	
 D3510. Տսլ	pplier's Representa	tive Completing Form	D3510A. First Name		D351	0B. Last Name	
			IMH	D			
D3520A. S	Street Address	D35	520B. City	D3520	C. State	D3	520D. ZIP Code
D3530A. F	Phone No.	D3530B. FAX No.					
D3900B.	Manufacturer's Su D3900C. HCPCS	ggested Retail Price (M		D3900E.	D3900F.	D3900G.	D3900H.
Item No.	Code	D3900D. Desci		Item Price	Quantity	Total Price	Approved Price
1						\$	\$
2						\$	\$
3						\$	\$
4						\$	\$
5						\$	\$
6						\$	\$
7						\$	\$
8						\$	Ś

DLN

Medicaid ID

DLN Medicaid ID Individual Name	
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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	DIFE	eterence			\$	\$
16					\$	\$
17		axed to th			\$ [\$
18					\$	\$
19					\$	\$
20					\$	\$
21					\$	\$
22					\$	\$
*Item Price must be based on MSRP. D3900I. Total Amount of All Items Requested				1.\$	2.\$	
D3900J. Minus 18%					1.\$	2.\$
D3900K. Grand Total					1.\$	2.\$

DLN	Medicaid ID	Individual Name	
Receipt Certification Upon receipt of a DME, the authori accordance with HHSC rules and p		DME meets the needs of the individual and that the specifications are as	intended ir
By signing the Attachment CMWC/		or Travel Restraint apist is certifying that the DME meets the needs of the individual and thacies. An attachment must be completed for each item requested and rec	
D3600. Therapist's Name	A. First Name	B. Last Name	
D3610. Therapist's License	A. License Type 1. Occup 2. Physic	·	
D3620. Therapist's Certification	Date	co Only Not	to
		Car Seat or Travel Restraint during that the DME has been delivered as prescribed	in the
D3630. NF Administrator's Nam	A. First Name	B. Last Name	
D3640. Special Needs Car Seat of Restraint Received Date	or Travel	AHP.	
D3650. NF Administrator's Certi	ification Date		

Specialized or Treated Pressure-Reducing	Support Surface Mattress
Environment Assessment - Specialized or Treated Pressure-Reduci	ng Support Surface Mattress
D4000A. Is the resident's living environment accessible and safe for 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. (minim	um 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 ski If the resident has a current education/vocational setting complete this	• • • •
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	nal therapist for this DME item:

Medicaid ID

DLN	Medicaid ID	Individual Name
Current DME Item - S	specialized or Treated Pressure-Reducing	g Support Surface Mattress
D4300. Does the resid	lent have a current DME item or items?	0. No 1. Yes
If No, Skip to Requesto If Yes, complete the fo	ed DME Item - Specialized or Treated Pressu ollowing:	ıre-Reducing Support Surface Mattress.
D4310. Describe the re (minimum of 50 chara		equested is a replacement), including the type and the age of the item.
For		e 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)
		THP.

DLN	Medicaid ID	Individual Name	
	em - Specialized or Treated Pressure-Reduc		
D4400. Describe the	DME item being requested (minimum of 50	characters):	
	Doforon	Oply N	0110
	neierenc	.e omy, r	Ot to
D4410. Describe the	medical necessity for the requested DME ite		
be			e or
D4420. Describe any	, anticipated modifications/changes to the re	equested DME item within the next five years (m	inimum of 50 characters):

			st access on a regular e, wheelchair, other) (s on the use of th	ne requested
L (or Ro	eter	ence		<u>)nl</u>	V,	No	tto
Supplier I	nformation and M	ISRP Quote						
Supplier I	nformation							
D4500. Su	pplier's Business N	ame		UII			ILE	
D4510. Su _l	pplier's Representa	tive Completing For	m D4510A. First	: Name		D451	0B. Last Name	
			TIM					
D4520A. S	Street Address		D4520B. City		D4520C	. State	D4	520D. ZIP Code
D4530A. F	Phone No.	D4530B. FAX No).					
		ggested Retail Pric	e (MSRP) Quote					
D4900B. Item No.	D4900C. HCPCS Code	D4900D.	Description of Item		D4900E. Item Price*	D4900F. Quantity	D4900G. Total Price	D4900H. Approved Price
1							\$	\$
2							\$	\$
3							\$	\$
4							\$	\$
5							\$	\$
6							\$	\$
7							\$	\$
8							\$	\$

Medicaid ID

DLN Medicaid ID Individual Name	
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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	DIFE	eterence			\$	\$
16					\$	\$
17	de l	axed to th			\$	\$
18					\$	\$
19					\$	\$
20					\$	\$
21					\$	\$
22					\$	\$
*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		
	st must verify that the DME meets the	e needs of the individual and that the specifications are as intended in
Therapist Certification of Delivered Spee By signing the Attachment CMWC/DME Receipt	Certification, the therapist is certifyin	ducing Support Surface Mattress ing that the DME meets the needs of the individual and that the hment must be completed for each item requested and received.
D4600. Therapist's Name	A. First Name	B. Last Name
D4610. Therapist's License	A. License Type	B. License No.
	1. Occupational 2. Physical	
D4620. Therapist's Certification Date	rence	Only, Not to
	Certification, the NF Administrator is	sure-Reducing Support Surface Mattress s attesting that the DME has been delivered as prescribed in the
D4630. NF Administrator's Name	A. First Name	B. Last Name
D4640. Specialized or Treated Pressure- Reducing Support Surface Mattress Received Date	TMH	P .
D4650. NF Administrator's Certification Date	te	

Medicaid ID

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
TALLD
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

Medicaid ID

DLN	Medicaid ID	Individual Name
Current DME Item - S	Standing Board/Frame	
D7300. Does the resic	dent have a current DME item or items?	0. No 1. Yes
If No, Skip to Request If Yes, complete the fo	ed DME Item - Standing Board/Frame. ollowing:	
D7310. Describe the r (minimum of 50 chara		equested is a replacement), including the type and the age of the item.
For		ce Only, Not to
be	Faxed to	the State or
D7320. Describe why	the current DME item(s) does/does not mee	et the resident's needs. (minimum of 50 characters)
	IIV	THP.

Requested DME Item - Standing Board/Frame	
Requested DME Item - Standing Board/Frame	
D7400. Describe the DME item being requested (minimum of 50 characters):	
For Reference Only, Not	
D7410. Describe the medical necessity for the requested DME item (minimum of 50 characters):	
be Faxed to the State of	
TMHP	
D7420. Describe any anticipated modifications/changes to the requested DME item within the next five years (minimum of	EO charactors)
D7420. Describe any anticipated modifications/changes to the requested Divisition within the next live years (minimum or	50 Characters).

			st access on a regular k e, wheelchair, other) (r				s on the use of th	ne requested
								4.4
) FR	erer	ence			Y /	110	
	nformation and M	ISRP Quote						
Supplier I	nformation							
D7500. Su	pplier's Business N	ame						
D7510. Supplier's Representative Completing Form D7510A. First Name					D751	0B. Last Name		
				4				
D7520A. Street Address D7520B. City				D7520C. State D7520D. ZIP Code				
D7530A. F	Phone No.	D7530B. FAX No	o					
		ggested Retail Pric	ce (MSRP) Quote					
D7900B. Item No.	D7900C. HCPCS Code	D7900D.	Description of Item		D7900E. Item Price*	D7900F. Quantity	D7900G. Total Price	D7900H. Approved Price
1							\$	\$
2							\$	\$
3							\$	\$
4							\$	\$
5							\$	\$
6							\$	\$
7							\$	\$
8							\$	\$

Medicaid ID

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 n accordance with HHSC rules and policies.	nust verify that the DME meets the needs of the	individual and that the specifications are as intended in
Therapist Certification of Delivered Standi By signing the Attachment CMWC/DME Receipt Ce specifications are as intended in accordance with H	ertification, the therapist is certifying that the DA	AE meets the needs of the individual and that the ecompleted for each item requested and received.
D7600. Therapist's Name	A. First Name	B. Last Name
·		
D7610. Therapist's License	A. License Type	B. License No.
	1. Occupational 2. Physical	
D7620. Therapist's Certification Date	renceron	
NF Administrator Certification of Delivered By signing the Attachment CMWC/DME Receipt Ce assessment to an individual who is a resident in the	ertification, the NF Administrator is attesting tha	t 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	TMHP.	
D7650. NF Administrator's Certification Date		

Medicaid ID