REQUEST FOR PRIOR AUTHORIZATION FOR HOME MODIFICATIONS AND/OR SPECIAL MEDICAL EQUIPMENT/REHAB EQUIPMENT

MID: ______________________________ Date of Assessment: ______________________________

Name: ____

Address: ____

DOB: ______________ Weight: ______________ Height: ________________

Physician's Name/RNP: ____

Diagnosis/Medical Condition: ____

Property: Owned/Family Owned or Rented (circle one). If rental, include form GW-RA.

Equipment currently utilized for mobility (check all that apply):

☐ Manual wheelchair ☐ Power wheelchair ☐ Scooter ☐ Walker ☐ Cane ☐ None

1. Functional Presentation:

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2. Requested Equipment/Accessories:

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3. Is this equipment replacing a similar piece of equipment? If yes, please justify why the existing equipment does not meet the recipient's needs:

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4. What other equipment has been considered before deciding on this equipment?

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5. Please explain why this equipment is necessary:

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6. Is the requested equipment the most cost-effective option available to safely meet the recipient's needs in the proposed environment?

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7. Has the equipment been tried in the home for fit/safe use? (If no, how was a determination made on the appropriateness of the equipment?):

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8. Has the recipient tried this equipment? If no, why not?

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9. Additional considerations:

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Please note: Each Medicaid member requiring Special Medical Equipment and/or Home Modifications totaling more than $20,000 combined over a five-year period will be subject to second level EOHHS review. Five-year period is determined from the date of the initial funded service.

It is the opinion of the following individuals that the requested equipment as stated above is beneficial for the care of this recipient:

______________________________	______________________________
Signature of Professional	Signature of Recipient/Guardian
______________________________	______________________________
Agency / Contact Number	Relationship