State of Rhode Island
Executive Office of Health and Human Services
Medicaid Program

PRIOR AUTHORIZATION REQUEST FOR DURABLE MEDICAL EQUIPMENT (DME) CHILDREN ONLY

(**Please note**: The following information on pages 1-3 must be completed by only the treating physician, therapist(s) and patient/parent/guardian.)

Date ____________________________

CHILD'S NAME ___________________________________ MID _____________________________

DOB ________________HEIGHT ____________________ WEIGHT ______________________

Diagnosis, and description of current status, relevant to this equipment need:

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____

1. Requested Equipment (including all accessories):

   ____

   ____

2. Is this equipment replacing a similar piece of equipment?

   a) YES (Please justify why current equipment does not meet the recipient's needs):

      ____

      ____

      ____

      ____

   b) NO – this is a new type of equipment/device (Please detail why this and all accessories are required at this time):

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      ____

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3. List all settings where item(s) will be used:

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4. List all equipment/devices considered before deciding on this particular item:

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5. Why was this particular item selected?

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6. Has the recipient trialed the equipment/device (i.e. loaner, demo)? If no, why not?

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7. Has the family been oriented/trained in use of equipment/device? (Mandatory for all Speech Generating Devices) If no, why not?

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8. If applicable, has equipment/device been tried in the recipient's home, auto, etc. for fit? If no, why not? (If not applicable, enter N/A)

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9. Please use the following space to include any additional relevant information that has not been previously stated:

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IMPORTANT:

It is the opinion of the following individuals that the requested equipment as stated above is medically necessary and beneficial for care of this recipient. It is also understood that the equipment will be used by the recipient in home and community settings, but not exclusively at school. Items needed to promote learning in school must be requested from the school through the Special Education process.

1. Signature of treating physician	**2.** Signature of recipient (or parent/guardian where applicable)
Physician name, **printed** Date	Recipient or parent/guardian name, **printed** Date
3. Signature of PT, OT, CCC-SLP **or** CCC-A, the ordering/ recommending clinician	**4.** School Therapist signature (advised if item may also be used at school location)
Clinician name, **printed** Date	School Therapist name, **printed** Date
Clinician's facility name/phone number	School name/ phone number