

MEDICAL EQUIPMENT REQUEST EVALUATION FORM Non Wheelchair

This evaluation must be completed by a New Hampshire licensed physician, occupational therapist, or physical therapist specializing in rehabilitation medicine. Evaluator must have an understanding of the recipient's condition for which the equipment is being requested and broad knowledge of the various rehabilitation equipment available in the market today that may benefit the recipient. **NOTE:** Requests for wheelchair equipment should **not** be made on this form. Wheelchair equipment requests should be made using Form 272M, "Mobility Evaluation."

PLEASE TYPE OR PRINT LEGIBLY:

Recipient Name: _____ NH Medicaid ID#: _____
(11 digits)

Mailing Address: _____ Date of Birth _____
Street City/Town Zip (MM/DD/YYYY)

Name of licensed MD/OT/PT Provider completing evaluation _____ NH Medicaid Provider # _____

MD OT/PT Provider Business Address: _____ Business Phone #: (____) _____ Ext: _____
Street Town Zip FAX #: (____) _____

Date of evaluation: _____ Recipient's Height: _____

Place of evaluation _____ Weight: _____

Primary Diagnoses: 1) _____
2) _____
3) _____

CHECK EQUIPMENT BEING REQUESTED:

Stander _____ Gait Trainer _____ Positioning Chair _____ Bath Equipment _____

Other (non wheelchair only - please describe) _____

Please provide medical justification for providing the equipment as requested above:

Is the requested equipment replacing a piece that the recipient currently has: Yes _____ No _____

Does the requested equipment duplicate a piece that the recipient currently has: Yes _____ No _____

If "Yes" to either, please answer the following:

Make and model of current equipment: _____

Age and condition of current equipment: _____

Reason for replacing or duplicating equipment at this time: _____

Where is the equipment to be used primarily? Home School Other _____

Given the recipient's current age and expected rate of growth, what is the anticipated number of years the recommended equipment is expected to be functional? _____

With respect to the growth potential of the recommended equipment, what is the maximum height and weight capacity? _____

How frequently is the equipment expected to be utilized each day, or week, and for how long each day or week? _____

Has the recipient completed a trial period of at least two (2) weeks with the recommended equipment? Yes No

Is similar equipment currently available or being utilized by the recipient at school, home or other site? Yes No

If "Yes" please explain: _____

Please identify any plans to obtain funding from any other sources (e.g., private insurance, grants, "Medicaid to School"): _____

What other, less costly equipment alternatives have been considered (provide specific makes and models)? Why were they not chosen? _____

Please explain why no other alternative equipment options were considered, if applicable: _____

Please check **all** that apply regarding the recommended equipment:

- Recipient's home has sufficient space to utilize and store the equipment.
- Potential growth of recipient has been taken into consideration in selecting the size of equipment, which should provide at **least 5 years of use.**
- Recipient or recipient's caregiver has demonstrated proficiency in the safe operation of the equipment.
- Less costly models have been ruled out as inappropriate.

Additional comments:

Signature of **NH licensed** OT/PT or physician completing the evaluation

Date

INDIVIDUALS PRESENT DURING EVALUATION:

- 1) _____ Representing/Relationship to recipient: _____
- 2) _____ Representing/Relationship to recipient: _____
- 3) _____ Representing/Relationship to recipient: _____

Recipient, Parent or Legal Guardian (please check the statement that applies):

_____ **I accept** the recommendations for the make, model and options of the equipment being requested and acknowledge that the safe operation and benefits of the equipment’s options and features have been fully explained to me. I have no questions or concerns regarding the recommendations made.

_____ **I do not** agree with all of the recommendations and I request changes based on the following:

 Signature of Recipient / Parent / Legal Guardian Relationship Date

MEDICAL EQUIPMENT SUPPLIER:

Place a check mark by all statements that apply to this request. If a statement does **not** apply, please provide your response in the comments section below:

- I concur with the recommendations made, and I am unaware of any other **less costly** equipment models or alternatives in the market at this time that would meet this recipient’s needs.
- To the best of my knowledge, the recipient does _____ does not _____ expect to receive a similar piece of equipment from any other funding source.

Comments: _____

 Signature - authorized representative of medical equipment supplier Printed name of authorized representative Date

 Printed name of medical equipment company

PLEASE SUBMIT AN **ORIGINAL**, COMPLETED FORM TO THE FOLLOWING ADDRESS. FAX’s or photocopies of this from will **not** be accepted. Please keep a copy of this completed form in your file in case we need to contact you concerning your request.

NH Medicaid
 Att: DME Prior Authorization Unit
 29 Hazen Drive
 Concord, NH 03301