



**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:

2. Requested Equipment/Accessories:

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:

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

5. Please explain why this equipment is necessary:

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

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?):

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

9. Additional considerations:

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