



Core and Preventive Home and Community Based Services Form Home Modifications, Special Medical Equipment, and Minor Environmental Modifications

Name: _____ MID# _____

Name of Physician/RNP: _____

Diagnosis: _____

1. Check One: Core Services Preventive Services

Minor Environmental Modifications: (Minor Assistive Devices): Please see definition (GW-AD1). Please note this service is available for members on Core and Preventive Services [HCPCS Code T2028].

Special Medical Equipment: Please see attached definition (GW-SM). Please note this service is available for members on Core Services only. Attach form (GW-EM1) [HCPCS Code T2029].

Home Modifications: Please see attached definition (GW-EM). Please note this service is available for members on Core Services only. Attach form (GW-EM1) [HCPCS Code S5165].

2. Description of Service(s) Requested: _____

3. Justification for Request (attach Form GW-EM1 if required): _____

4. Professional requesting: Physician PT/OT RN DHS SCW Other

(If other, please provide Title/Credentials) _____

By submitting and signing this form, the above professional ensures the following:

- **No other payer:** The equipment or modification(s) are not otherwise available through Medicare, Medicaid, or other private insurance coverage.
- **Effectiveness:** Skilled professionals (e.g. PTs, OTs, Mobility Specialists) have properly identified the individual's need for the recommended equipment and/or modifications. Furthermore, the recommendation complies with the Limitations and Special Considerations as defined by the 1115 Demonstration Waiver for Minor Assistive Devices, Special Medical Equipment or Environmental Modifications.

Name of Professional (print) _____ **Tel. #** _____ **Fax #** _____

Signature of Professional _____ **Date** _____ **LTC RL** _____

-For Official Use Only-

The above request is: **Approved** **Denied** **Cost \$** _____

Reason for denial: _____

Authorized Signature: _____ **Date:** _____