MAP 95 (Rev. 6/07)

Commonwealth of Kentucky Cabinet for Health and Family Services Department for Medicaid Services

REQUEST FOR EQUIPMENT FORM

RECIPIENTS NAME:		DOB: DX:		
MAID or MEMBER #:				
Estimated Time Needed: On	Months Indef	initely Perr	nanently 🗌	
Procedure Code:		Date:		
ITEM	ESTIMATE 1	ESTIMATE 2	ESTIMATE 3	TOTAL COST (includes shipping)
AGENCY NAME:	•			
PROVIDER NUMBER:				
CASE MANAGER/SUPI	PORT BROKER:			
TELEPHONE NUMBER	.: 			
AUTHORIZED DMS SIG	GNATURE:			
DATE APPROVED:				

