

DURABLE MEDICAL EQUIPMENT/ENVIRONMENTAL MODIFICATION

REQUEST FOR LIFEWAYS CMH FUNDING

Request Date \_\_\_\_\_ Consumer \_\_\_\_\_ LEO # \_\_\_\_\_

1. Adaptive Equipment (Attach original Physician Prescription)

(Must attempt to bill consumer's insurance first and attach denial)

- T1999-Miscellaneous therapeutic items
- T2028-Specialized supply, not otherwise specified, waiver
- T2029-Specialized medical equipment, not otherwise specified, waiver
- S5199-Person care items, not otherwise specified (assistive technology)
- E1399-Durable medical equipment-miscellaneous
- T2039-Van lifts and wheelchair tie down systems

2. Environmental Modification (Attach original Physician Prescription)\*\*

- S5160-Emergency response system, installation and testing
- S5161- PERS service fee, per month
- S5165- Home modification, per service

\*\*Note-Home modifications for properties not owned by the consumer require property owner's approval

3. OT/PT-Evaluation/ Consult note attached  Yes  No

Description and Justification for use of LifeWays Funds

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_  Approved  Declined  Deferred  
Support Coordinator/Case Manager Reason : \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_  Approved  Declined  Deferred  
Utilization Mgmt Approval Reason: \_\_\_\_\_

Price Quote #1 \_\_\_\_\_ Comment(s) \_\_\_\_\_

Price Quote #2 \_\_\_\_\_ Comment(s) \_\_\_\_\_

Price Quote #3 \_\_\_\_\_ Comment(s) \_\_\_\_\_

Vendor Name/Phone/Email: \_\_\_\_\_ Purchase amount \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Purchaser sign off \_\_\_\_\_ Date \_\_\_\_\_

Contract Dept vendor setup/sign off \_\_\_\_\_ Date \_\_\_\_\_

UM auth set up/sign off \_\_\_\_\_ Date \_\_\_\_\_

**Purchaser sign off on price quote, attach authorization and physician script, submit to vendor and notify requester**

Final sign off of purchase date completion \_\_\_\_\_ Date \_\_\_\_\_

**LifeWays Finance Department to forward copy of completed DME form to medical records for scanning**