MAP 95Commonwealth of Kentucky(Rev. 6/07)Cabinet for Health and Family Services Department for Medicaid Services				
REQUEST FOR EQUIPMENT FORM				
RECIPIENTS NAME:	DOB:			
MAID or MEMBER #:			DX:	
Estimated Time Needed: Months Indefinitely Permanently One Time Only				
Procedure Code:	Date:			
ITEM	ESTIMATE 1	ESTIMATE 2	ESTIMATE 3	TOTAL COST (includes shipping)

AGENCY NAME:

PROVIDER NUMBER:

CASE MANAGER/SUPPORT BROKER:

TELEPHONE NUMBER:

AUTHORIZED DMS SIGNATURE:

DATE APPROVED:

