Limitation Extension Request
Incontinent Supplies and Gloves

Washington State Health Care Authority

This is confidential information intended only for the person to whom it is faxed. In addition to this form, you must send a completed HCA Rx form (HCA 13-794) **(hca.wa.gov/assets/billers-and-providers/13_794.pdf)**. Please return this form by Online direct data entry **(hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/prior-authorization-pa)** or fax to the Medical Equipment (ME) Unit at **1-866-668-1214**

1 To be completed by vendor or clinician

Contact name _____ Phone number (xxx-xxx-xxxx) _____ Fax number (xxx-xxx-xxxx) _____

Provider name _____ Provider NPI number _____

Clinical contact _____ Phone number (xxx-xxx-xxxx) _____ Fax number (xxx-xxx-xxxx) _____

Client name _____ Client ID _____

2 To be completed by clinician

For incontinent supplies

1. What is the medical diagnoses(s) requiring additional incontinent supplies? _____
2. What is the frequency of use of incontinent supplies per day? _____
3. Has the frequency changed recently? ☐ Yes ☐ No If yes, why? _____
4. What type of medications does the client currently use that may affect the amount of incontinent products required per month? _____
5. Has a bowel/bladder program been tried? ☐ Yes ☐ No
6. If yes, what was the outcome? _____
7. Is client incontinent? ☐ bladder ☐ bowel ☐ both

For sizing that does not fit into the allowables

Waist measurement _____ Hip measurement _____

For gloves

1. What is the medical diagnoses(s) requiring additional gloves? _____
2. What is the frequency of use of gloves per day? _____
3. Has the frequency changed recently? ☐ Yes ☐ No If yes, why? _____
4. Does the client have multiple non-family caregivers? ☐ Yes ☐ No
   If yes, how many? _____ How many hours per day? _____
5. Where does the client reside?
   ☐ Private home ☐ Adult family home or boarding home (e.g. ALF) ☐ Other state-funded living

Please note: All supplies are authorized for one year. New documentation must be submitted yearly.

Physician (or prescribing provider) signature _____