



Durable Medical Equipment Program Management Unit (DMEPMU)

P.O. BOX 45535

OLYMPIA, WA 98504-5535

**Durable Medical Equipment**

Fax number: 1-866-668-1214

**NOTE: Do not alter this form in any way. The form may only be completed by a qualified provider, acting within the scope of their practice as required by WAC 388-543-1100(1)(d), and all spaces must be completed. The form must be signed and dated within 60 days of HRSA receiving the request.**

**This form is required in addition to a prescription.**

**SECTION 1**

CLIENT NAME		CLIENT ID		DATE OF REQUEST	
What is the diagnosis/medical condition that requires the use of this equipment? (Do not use ICD9 codes for the diagnosis.)					
Length of Need In Months Or Years	How Many Hours A DAY is there a CAREGIVER?	How Many Caregivers?	Client Height	Client Weight	

**SECTION 2**

Equipment Requested:

What is the specific medical need for the equipment requested including all related accessories and modifications?

What other alternative and less expensive equipment have been tried? What were the results of the trials?

Why won't less costly alternatives meet the client's needs?

Does client already own similar equipment? If so, why does it not meet their current medical needs?

**SECTION 3 (Required for Bathroom Equipment Only)**

Does the client have a roll-in shower?  YES  NO    Does the client own their home?  YES  NO    Provide Photos if available.

Bathroom Measurements:      Doorway? \_\_\_\_\_      Room Length? \_\_\_\_\_      Room Width? \_\_\_\_\_

What is the client's transfer status?

Additional comments:

**SECTION 4**

PHYSICIAN'S OR THERAPIST SIGNATURE		DATE
PRINTED NAME		REFERRING PHYSICIAN NUMBER
TELEPHONE NUMBER		FAX NUMBER