Washington State Health Care Authority

Limitation Extension Request
Incontinent Supplies and Gloves

Attention: DME Program Manager
Durable Medical Equipment (DME) Program Management Unit
PO Box 45535 Olympia, WA 98504-5535
Fax:1-866-668-1214

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).

To be completed by vendor or clinician		
CONTACT NAME	PROVIDER NAME	
PHONE NUMBER	FAX NUMBER	PROVIDER NPI NUMBER
CLINICAL CONTACT	PHONE NUMBER	FAX NUMBER
CLIENT ID	CLIENT'S NAME	

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 dual incontinent? ☐ Yes ☐ No

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? 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

FOR SIZING THAT DOES NOT FIT INTO THE ALLOWABLES

1. Waist measurement_______________________ Hip Measurement__________________________________

Please note: *All supplies are authorized for 1 year. New documentation must be submitted yearly.*

PHYSICIAN (OR PRESCRIBING PROVIDER) SIGNATURE	DATE