RI Department of Human Services
Division of Healthcare Quality, Financing And Purchasing
Center for Child and Family Health

REQUEST FOR PRIOR AUTHORIZATION FOR
DURABLE MEDICAL EQUIPMENT (DME) –Children Only

Please note: The following information on pages 1-3 must be completed (or filled out) by only the treating physician, therapist(s) and patient/parent/guardian.

Date: ________________________________

CHILD'S NAME: ____ MID#:_________________

D.O.B. _____________ Height: ____________ Weight: ____________

Diagnosis (ICD9) and description of current status, relevant to this equipment need:

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1) Requested Equipment (including all accessories):

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2) Is this equipment to replace a similar piece of equipment? Circle/complete one.

a) YES. (Please justify why the current equipment does not meet the recipient's needs):

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b) No, this is a new type of equipment/device. (Please detail why this and all accessories are required at this time)

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3) List all setting where item(s) will be used:

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4) Please list all equipment/devices considered before deciding on this particular item:

5) Why was this particular item/product selected?

a) Has the recipient had trial use (i.e. loaner, demo)? If no, why not?

b) Has family been oriented/trained in use of device/equipment? (Mandatory for all speech generating devices) If no, why not?

c) If applicable to item use, has this equipment been tried in the recipient's home, auto, etc. for fit? If no why not? (If not applicable, enter N/A)

Please use the following space to include any additional relevant information that has not been previously stated:

IMPORTANT:

It is the opinion of the following individuals that the requested equipment as stated above is medically necessary and beneficial for care of this recipient. It is also understood that the equipment will be used by the recipient in home and community settings, but not exclusively at school. Items needed to promote learning in school must be requested from the school through the Special Education process.

1. Signature of treating physician	**2.** Signature of recipient (or parent/guardian where applicable)
Physician name, **printed** Date	Recipient or parent/guardian name, **printed** Date
3. Signature of PT, OT, CCC-SLP **or** CCC-A, the ordering/ recommending clinician	**4.** School Therapist signature (advised if item may also be used at school location)
Clinician name, **printed** Date	School Therapist name, **printed** Date
Clinician's facility name/phone number	School name/ phone number