Ohio Department of Medicaid

# REQUEST FOR NEED VERIFICATION: REPAIR OF DURABLE MEDICAL EQUIPMENT (OTHER THAN WHEELCHAIRS), PROSTHESES, OR ORTHOTIC DEVICES

| **Individual** | **Provider** |
| --- | --- |
| Name | Name |
| Medicaid ID number | Medicaid provider number |
| Date of birth | NPI |

**Repair Information**

| | |
| --- | --- |
| Specification of the item, including manufacturer, model, and serial number (if applicable) | |
| Date on which the item was originally purchased or dispensed or, if the date is not known, the approximate age of the item | Warranty period and type (manufacturer or dealer) |
| Full description of wear, damage, or malfunction | |
| Full description of the repair | |
| Description, with dates, of previous repairs (both major and minor) | |
| Complete itemization of parts | |
| Estimate of labor time needed | |
| Other comments | |

| Name of provider representative | Signature | Date of signature |
| --- | --- | --- |
| | | |

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