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