General Assistance Medical Program
DME Request

Date:_____

Provider: _____ Tax ID No.:_____

Address Service(s) is being provided from:_____

Phone No._____ **Fax No**._____

Patient Name(last name first):	**DOB:**	**SS#**
Delivery/ Rental Date(s) of supplies:	**GAMP Eligibility Dates:**	
Diagnosis: (include MD order if this is a new request)		

Equipment/Supplies Requested

HCPC Number	Units/ Pks	Qty.	Item	Cost

Each HCPC must correlate to a specific item. Do not include misc. supplies.

Units/Pks is the number of items in the package, which may vary due to different manufacturers used by each provider.

Quantity reflects the number of units being requested.

Cost can be no higher than Medicaid rates.

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All relevant medical documentation to support request

Other:

For GAMP UM Use Only

Todays Date:	Auth No.:
Primary Care Clinic:	Service Dates:
	Provider:
Signature:	Provider Number:

Updated 2/2008

Authorized Fee at GAMP Reimbursement Schedule

Issuance of number indicates medical necessity, and does not necessarily guarantee payment of services.

Please FAX form to: (414) 289-8516 Telephone (414) 289-6731