



HRSA Limitation Extension Request Incontinent Supplies and Gloves

Division of Eligibility and Service Delivery – Authorization Services Office
PO Box 45535 Olympia, WA 98504-5535

This is confidential information only intended for to whom it is faxed

To: DME Program Manager

DME Providers Fax Number: 1-866-668-1214

In addition to this form, you must send the following: Completed 1500 form and HRSA Rx form, DSHS 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
5. If yes, how many? ____ How many hours per day? ____
6. Where does the client reside?
 Private Home Adult Family Home or Boarding Home (e.g. ALF) Other State funded living

Please note: *If the patient is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least once per year. If documentation is not available to support the dispensing of excessive utilization of these supplies, suppliers are not allowed to bill for these supplies, as they will not be covered by Medicaid.*

PHYSICIAN (OR PRESCRIBING PROVIDER) SIGNATURE	DATE
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