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Cañon City, CO 81212
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La Vista, NE 68128
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**DURABLE MEDICAL EQUIPMENT
AUTHORIZATION FOR PURCHASE OF MEDICAID/MEDICARE ITEM**

In order to best serve our clients' durable medical equipment (DME) needs, we are asking for the appropriate persons involved in the client's life to assist us in ensuring that the correct DME is ordered. Please review the attached information on the specific DME and sign below indicating that the correct item(s) has/have been selected.

Please check ONE:

- ☐ *I need this product now. Please order immediately and I will take financial responsibility if insurance coverage is not approved.*
- ☐ *Please wait for insurance to approve coverage before ordering this product.*

If this product is needed prior to Medicaid/Medicare/Other Insurance approval, the responsible party will take financial responsibility in the event approval is not granted.

Date sent to agency/responsible party: _____

AGENCY/RESPONSIBLE PARTY: _____

CLIENT'S NAME: _____

CLIENT'S ADDRESS: _____
(product will be sent to this
Location unless otherwise indicated): _____

PRODUCT DESCRIPTION: (also see attached documentation): _____

Amount of product plus shipping and handling: \$ _____

I understand that ALL PRODUCTS ORDERED AND RECEIVED ARE NON-RETURNABLE.

I have reviewed the documentation of the product(s) and am aware of the client's need for this product.

For Office Use Only:

Sales Initials _____

Date _____

Mgmt Initials _____

Date _____

Client/Responsible Party Signature

Date