NEW HAMPSHIRE MEDICAID

286
SR 10xx
01/10

REQUEST FOR INCONTINENCE PRODUCT NOT ON PRODUCT OFFERING SHEET

Directions:

1. This form is to be completed by the New Hampshire Medicaid provider.
2. Please print or type all requested information.
3. Fax completed form to Gulf South Medical Supply at 904-380-4537. Include any physician documented information available. For assistance contact 904-380-4537.
4. A representative from Gulf South Medical Supply may contact you about your submission.

TO BE COMPLETED BY PROVIDER

RECIPIENT INFORMATION

Medicaid ID#_____ DOB_____

Name_____ Telephone_____

Street_____ City/Town_____ State_____ Zip_____

PROVIDER INFORMATION

Date of request_____

Provider Name_____ Contact Name_____

Telephone_____ NH Medicaid Provider ID_____

Street_____ City/Town_____ State_____ Zip_____

REQUEST DETAIL

Please document attempt(s) to fit the recipient with products on the product offering sheet and explain why the product(s) was (were) not effective (use separate sheet if necessary):

_____

_____

_____

_____

_____

_____

Please indicate which product is requested to solve for failure or ineffectiveness.

_____

_____

PROVIDER SIGNATURE

I certify that the above information is true and accurate to the best of my knowledge.

_____ _____

Signature Date

_____ _____

Print Name Title

PLEASE FORWARD THIS INFORMATION TO GULF SOUTH MEDICAL SUPPLY

435 Southpoint Boulevard ■ Jacksonville, Florida 32216 ■ FAX: (904)-380-4537