



NEW HAMPSHIRE MEDICAID

QUOTE FOR AUGMENTATIVE AND ALTERNATIVE COMMUNICATION (AAC) AIDS FUNDING REQUEST

RECIPIENT INFORMATION						
Name:		Medicaid ID #:		DOB:		
PROVIDER INFORMATION						
Contact Person:			Request Date:			
Provider Name:			Medicaid Provider ID#:			
Address:			Telephone #:		Fax #:	
ICD-9 Codes(s):			Written Diagnosis:			
EQUIPMENT SUPPLY INFORMATION						
Item Requested	Procedure Code	# of Units	Acquisition Cost (per unit)	Usual and Customary Charge	Monthly Rental Charge	New or Used?
AAC Provider Signature			Date			
Printed Name of AAC Provider			Title			

Submit this form (Form #288-Q) along with the Funding Information (Form #228-F), a Safeguarding Plan (Form #288-SG), a Trial Summary (Form #288-T), a prescription for the recommended equipment, and a completed AAC evaluation to:

Medicaid Medical Services
129 Pleasant St., Concord, NH 03301
Fax: 603-314-8101
Email: ServiceAuthorizationFFS@dhhs.nh.gov