

MAP-248
(Rev. 12/01)

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Home Health Program

Agency Name _____ Provider # _____

Agency Address _____

CERTIFICATION FOR DISPOSABLE MEDICAL SUPPLIES

Patient's Name _____ MAID # _____

Address _____ Medicare # _____

_____ Birthdate _____

Other Insurance _____

Diagnosis _____

This is to certify that the following medical supplies are essential to meet the medical needs of this recipient.

(Indicate Directions for Use of the Supplies) _____

Anticipated Duration of Need: _____ 1-30 Days _____ 1-6 Months _____ Lifetime _____ Indefinite

I, _____ certify this patient requires the supplies listed above.
Physician's Signature

Address _____ License # _____ Date _____

Must be signed and dated by the physician every 6 months.