Cabinet for Health and Family Services
Department for Medicaid Services
Durable Equipment Provider

ADVANCE MEMBER NOTICE

Note: You will need to make a choice about receiving the listed health care items or services.

- **Please read the entire notice carefully.**
- **If you do not understand any part, please ask to have this form explained to you.**
- **You may reach Department for Medicaid staff at 502-564-2687 if you are still unsure about the information contained on this form.**

Items or Services:
Because: The items or services are not covered under the Ky Health Choices program administered by the Department for Medicaid Services Durable Medical Equipment (DME) program.

If an item or service was denied due to failing to meet medical necessity or the supplier failed to obtain a prior authorization timely and the item(s) and/or service(s) has already been provided to you, you are not obligated financially.

If you have been made aware with the signing of this form that you are obtaining a non-covered item or service, and you elect to obtain the item or service, you will be expected to be responsible for the payment.

Option 1: YES, I want to receive the item or service. I will be responsible for paying for the item or service.

Name: _____ Date: _____
Signature: _____ Member #: _____
Member or authorized representative

Option 2: NO, I do not want to receive the item or service.

Name: _____ Date: _____
Signature: _____ Member #: _____
Member or authorized representative

Supplier Information:
Name of Supplier: _____ Supplier #: _____
Supplier signature: _____ Date: _____

Note: Your health information will be kept confidential. Any information that is collected with this form is kept private in our office. This information may be shared with KyHealth Choices (Department for Medicaid Services).

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