Reset Form

T2029 Equipment and Supplies Waiver Service Approval Form
Care Coordinator Use Only

FYI ***Incomplete, illegible or inaccurate forms will be returned to sender.*** Please complete the entire form. Allow 14 calendar days for processing of this request.

Fax form and any relevant documentation to: **612-884-2185** or **1-866-402-5018** **OR**

Email: CLSintake@ucare.org

For questions, **call: 612-676-6705**

MEMBER INFORMATION

Member Name _____ Member ID _____

Address _____ PMI _____

City, State, Zip _____ Date of Birth _____

Phone _____ Gender: ☐ Female ☐ Male

CC INFO

Care Coordinator Name _____ Phone _____

Care Coordinator Email _____ Fax _____

Waiver Span Start Date _____ Waiver Span End Date _____

Please note: services should not be authorized past the end of the waiver span. If a new assessment is performed, all previously authorized services must also be renewed.

ITEMS REQUESTED

LIFT CHAIR REQUEST (see page 2 for additional T2029 options)

Service Description Select a Service

Start Date _____ Frequency _____

End Date _____ Total Units _____

Rate per unit _____

MHCP Criteria for Lift Chairs: Seat lift mechanisms are **covered** for members who meet all of the following:

1. The member has arthritis of the hip or knee, neuromuscular disease or another medical condition that affects his or her strength or mobility
2. The member is unable to stand up from a regular armchair at home
3. Once standing, the member has the ability to ambulate independently or with a properly fitted walker or cane. **Does this member meet criteria 3?* ☐ Y ☐ N

***For a member to be eligible for a lift chair under the medical benefit or Elderly Waiver, criteria 3 must be met.**

Provider Name _____ Phone _____

EW UMPI/NPI*** _____ Fax _____

****To ensure accurate claims payment, please verify with the provider the billing UMPI/NPI for EW services.*

Agency Email Address _____

Please provide an explanation and documentation to support request and manufacturer list price of mechanism vs. furniture.

Waiver Service Approval Form (continued)

ITEMS REQUESTED

SERVICE AGREEMENT

Service Description Select a service

Start Date _____ Frequency _____

End Date _____ Total Units _____

Rate Per Unit _____

Item HCPCS code (if applicable): _____

Item meets coverage criteria for MA, Medicare, other payer or TPL*? ☐ Y ☐ N

**Durable medical equipment with HCPCS codes should be verified for coverage under Medicare, MA, or other insurance payer prior to submission under Elderly Waiver. If member qualifies for a DME item under DHS medical criteria, the requested item must be submitted under the medical benefit first.*

Provider Name _____ Phone _____

EW UMPI/NPI** _____ Fax _____

***To ensure accurate claims payment, please verify with the provider the billing UMPI/NPI for EW services.*

Agency Email Address _____

Please provide an explanation and documentation to support request, including qualifying diagnosis if applicable. (If adjusting authorization due to case mix change, DTR is required. For all other changes to existing authorizations, specific details required.) Members residing in Customized Living do not qualify for continence wipes.

ITEMS REQUESTED

SERVICE AGREEMENT

Service Description Select a service

Start Date _____ Frequency _____

End Date _____ Total Units _____

Rate Per Unit _____

Item HCPCS code (if applicable): _____

Item meets coverage criteria for MA, Medicare, other payer or TPL*? ☐ Y ☐ N

**Durable medical equipment with HCPCS codes should be verified for coverage under Medicare, MA, or other insurance payer prior to submission under Elderly Waiver. If member qualifies for a DME item under DHS medical criteria, the requested item must be submitted under the medical benefit first.*

Provider Name _____ Phone _____

EW UMPI/NPI** _____ Fax _____

***To ensure accurate claims payment, please verify with the provider the billing UMPI/NPI for EW services.*

Agency Email Address _____

Please provide an explanation and documentation to support request, including qualifying diagnosis if applicable. (If adjusting authorization due to case mix change, DTR is required. For all other changes to existing authorizations, specific details required.) Members residing in Customized Living do not qualify for continence wipes.

Notes: T2029 – Supplies/Equipment: Please refer to EOC.
This approval form does not guarantee payment; benefits are subject to eligibility at the time service is being rendered.

Waiver Service Approval Form (continued)

ITEMS REQUESTED

ADDITIONAL NOTES/DOCUMENTATION TO SUPPORT REQUEST

Notes: T2029 – Supplies/Equipment: Please refer to EOC.
This approval form does not guarantee payment; benefits are subject to eligibility at the time service is being rendered.