LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

Assistive Devices and Medical Supplies Form

Participant's Name: _____ DOB: _____ Last 4 digits of SSN: _____

Address: _____

Responsible Representative (if applicable): _____ RO: _____

SC Agency: _____ SC: _____

**** Assistive Devices (Z0624) or Medical Supplies(Z0645) exceeding $500 cost must be submitted to Regional Office for review.***

I. Assistive Devices and Medical Supplies Expenses billed by SCA *

Procedure Code	Item	# of Items Requested	Cost per Item	Total Cost*
------				$ 0.00
------				$ 0.00
	Totals:	----------		$ 0.00

II. Assistive Devices and Medical Supplies Expenses billed by Assistive Devices provider (Provider Type 17)

Procedure Code	Item	# of Items Requested	Cost per Item	Total Cost
-------				$ 0.00
-------				$ 0.00
	Totals:	----------		$ 0.00

III. Designated Purchaser (DP) Information *(if applicable)*

Name: _____ Signature: _____

Address: _____

Email: _____ Phone Number: _____

Assistive Devices and Medical Supplies Provider Information *(if applicable)*

Name: _____ Signature: _____

Address: _____

Email: _____ Phone Number: _____

IV. Final Approval

By signing, I verify that I have reviewd this form and the item(s) receipt(s) for actual expenditure.

Total Final Cost Authorized: $ 0.00

SC Signature: _____ Date: _____

SC Supervisor Final Determination Signature: _____ Date: _____