T2029 Equipment and Supplies Waiver Service Approval Form

Care Coordinator Use Only

Reset Form

Incomplete, illegible, or inaccurate forms will be returned to sender.

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 (Option 2, then Option 5)

Complete the steps below:

1. Connect with DME provider to determine if a doctor's order is needed for the item.
2. Obtain HCPCS Code(s) from the DME Provider, if applicable.

Review if covered by other sources:

3. Review alternative coverage sources including:
   CMS National Coverage Determination
   MHCP Provider Manual – Equipment and Supplies
4. If item is covered under the member's Medicare or Medicaid benefits, inform DME company to bill the item under the medical benefit.
5. Review UCare supplemental benefits to determine coverage.
6. Determine if an alternative covered item available to meet member's need by discussing w/member and primary care team.

If item is not covered by other payor sources and/or DME has received a claim denial, proceed with next steps: Review eligibility criteria CBSM - Specialized equipment and supplies (state.mn.us):

7. A person is eligible to receive specialized equipment and supplies if the item allows the person to do one of the following:
   - Communicate with others
   - Perceive, control, or interact with their environment
   - Perform activities of daily living (ADLs)

STOP: If request doesn't meet one of the three above, it is not appropriate to cover under EW T2029.

8. Review EW T2029 Equipment and Supplies Coverage Guide for UCare guidance.
9. Review with Supervisor as outlined in the EW T2029 Equipment and Supplies Coverage Guide.
10. Review DHS-3945 Long-Term Services and Supports Service Rate Limits to ensure item(s) fits within member's case mix budget cap.

☐ I attest that each item listed below on this Waiver Approval Form has been reviewed using the checklist above.

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.)

T2029 Waiver Service Approval Form

MEMBER INFORMATION

Member Name _____ Member ID _____

Date of Birth _____ PMI _____

Phone _____

CARE COORDINATOR

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 next page for additional T2029 options)

Service Description Select a Service

Start Date _____ Frequency _____

End Date _____ Total Units _____

Rate per unit _____ Eligibility: Select Eligibility Criteria

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

Provider Email Address* _____ Fax _____

EW UMPI or NPI* _____

***To ensure accurate claims payment, please verify with the provider their email address and billing UMPI or NPI for EW services.**

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

T2029 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):_____ Eligibility: Select Eligibility Criteria

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

Provider Name _____ Phone _____

Provider Email Address* _____ Fax _____

EW UMPI or NPI* _____

***To ensure accurate claims payment, please verify with the provider their email address and billing UMPI or NPI for EW services.**

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.)

ITEMS REQUESTED

SERVICE AGREEMENT

Service Description Select a service

Start Date _____ Frequency _____

End Date _____ Total Units _____

Rate Per Unit _____

Item HCPCS code (if applicable):_____ Eligibility: Select Eligibility Criteria

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

Provider Name _____ Phone _____

Provider Email Address* _____ Fax _____

EW UMPI or NPI* _____

***To ensure accurate claims payment, please verify with the provider their email address and billing UMPI or NPI for EW services.**

Notes: ***This approval form does not guarantee payment; benefits are subject to eligibility at the time service is being rendered.***

T2029 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):_____ Eligibility: Select Eligibility Criteria

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

Provider Name _____ Phone _____

Provider Email Address* _____ Fax _____

EW UMPI or NPI* _____

***To ensure accurate claims payment, please verify with the provider their email address and billing UMPI or NPI for EW services.**

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.)

ITEMS REQUESTED

SERVICE AGREEMENT

Service Description Select a service

Start Date _____ Frequency _____

End Date _____ Total Units _____

Rate Per Unit _____

Item HCPCS code (if applicable):_____ Eligibility: Select Eligibility Criteria

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

Provider Name _____ Phone _____

Provider Email Address* _____ Fax _____

EW UMPI or NPI* _____

***To ensure accurate claims payment, please verify with the provider their email address and billing UMPI or NPI for EW services.**

Notes: ***This approval form does not guarantee payment; benefits are subject to eligibility at the time service is being rendered.***