# Medical Equipment Request Form

*This form is used to formally request or authorize the allocation or usage of specific medical equipment such as wheelchairs, oxygen tanks, hospital beds, and other assistive devices. Please ensure all fields are completed accurately to facilitate the review and fulfillment process.*

## Requestor Information

* **Full Name:** {fullName}
* **Date of Birth:** {dateOfBirth}
* **Contact Number:** {contactNumber}
* **Email:** {email}
* **Address:** {address}

## Equipment Request Details

* **Equipment Type:** {equipmentType}
* **Reason for Request:** {reason}
* **Duration of Use:** {duration}
* **Date Needed:** {dateNeeded}

## Medical Provider Authorization

* **Physician Name:** {physicianName}
* **Facility/Institution:** {facility}
* **Contact Information:** {physicianContact}
* **Prescription Attached:** {prescriptionStatus}

{#hasInsurance}

## Insurance Information

* **Insurance Provider:** {insuranceProvider}
* **Policy Number:** {policyNumber}
* **Contact for Claims:** {claimsContact}

{/hasInsurance}

{^hasInsurance}

*This request does not include insurance coverage information. The requester acknowledges full responsibility for the cost or reimbursement arrangement.*

{/hasInsurance}

## Requested Items

|  |  |  |
| --- | --- | --- |
| **Item** | **Quantity** | **Additional Notes** |
| {#items}{itemName} | {quantity} | {notes}{/items} |

## Acknowledgment & Signature

**Requester Name:** {requesterName}

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** {submissionDate}

By signing above, the requester confirms the accuracy of the information provided and agrees to comply with all relevant policies and procedures related to the use and return of medical equipment.