TEMPORARY REPLACEMENT EQUIPMENT FORM

Commonwealth of Massachusetts | Executive Office of Health and Human Services | www.mass.gov/masshealth

This form is to be used for billing MassHealth durable medical equipment code K0462 for temporary replacement equipment for MassHealth member-owned equipment that has been determined to be unusable and requires repair.

Claims must be submitted using HCPCS service code K0462. This form must be completed and attached to the claim for processing. If this form is not completed and attached to the claim, the claim will deny.

If the same piece of equipment needs further repair at a later time, a new form must be completed and attached with a new claim. Each claim will be manually reviewed by MassHealth.

Member's Name	MID #
Primary HCPCS Code of Item Being Repaired	Date of Purchase
Date Temporary Replacement Equipment Delivered to Member	

101 CMR 322.00 KJ Fee for primary HCPCS of item being repaired: $ _____ (See following link for pricing.)

101 CMR 322.00: Durable Medical Equipment, Oxygen and Respiratory Therapy Equipment

HCPCS code description, manufacturer, serial number(if applicable), and brand name of equipment being repaired

Expected repair time and additional comments

PROVIDER OF DME ATTESTATION, SIGNATURE, AND DATE

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and it is true, accurate, and complete, to the best of my knowledge. I also certify that I am the provider or, in the case of a legal entity, duly authorized to act on behalf of the provider. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material contained herein.

Note: Signature and date stamps (including electronic signature), or the signature of anyone other than the provider of DME or a person legally authorized to sign on behalf of the legal entity, are not acceptable.

Name of Provider	MassHealth Provider #
Signature of Employee Completing This Form	Date
Printed Name of Employee	