Please complete the following if you are contacted by a Medicaid recipient who asks for assistance in finding a Medicaid provider of **OSTOMY PRODUCTS**:

Name: _____

Medicaid ID No.: _____ Recipient's Age: _____

Area and Island of Residence *(example: Hilo, Hawaii)*: _____

Telephone No.: _____

If the recipient has no phone no., please give the name and phone no. of a relative or friend who can take a message for the recipient:

Name: _____

Telephone No.: _____

Physician's Name: _____

Physician's Phone No.: _____

Your Name: _____

Your Division and Branch: _____

Your Telephone No.: _____

[ ] CHECK here if recipient says that he/she will run out of ostomy products in a week or less

FAX this form to the MSB at 692-8131.