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STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Medical Standards Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

Dear Medicaid Recipient Who Requires Ostomy Products:

RE: CERTIFICATION FOR OSTOMY PRODUCTS

To help you get the ostomy supplies you need and your doctor requests, we ask that you choose one (1) provider that you will use to get your ostomy supplies. If you cannot get all the ostomy supplies you need from one (1) provider, please let all the providers you are using know what items you are getting from each provider and how many.

Also, to help Medicaid and your ostomy provider(s), we ask that you read and sign the statement below:

CERTIFICATION

(Check the box that applies to you)

[ ] I hereby certify that I have not received ostomy supplies in the last month (30 days) from any other provider.

[ ] I hereby certify that I have received ostomy supplies in the last month (30 days) from _____, but these are NOT the same type of supplies that I
name of provider
am getting from _____.
name of this provider

_____ _____
Signature *Date*

If not signed by the Medicaid recipient, please check your relationship to the recipient:

[ ] Parent, legal guardian

[ ] Caregiver

[ ] Other, *describe*: _____