

Complex Equipment Request Form

Maryland Durable Medical Equipment Re-Use Program

Asterisked (*) fields are required. Failure to provide this information will void your request.

The following people must be identified: 1) The person requesting the equipment (Requestor). 2) The beneficiary of the equipment (Beneficiary). 3) The person picking up the equipment. 4) The licensed health care professional approving the use of the equipment for the Beneficiary. The Requestor is the person completing and executing this form and who will take ownership of the equipment. The Beneficiary is the person with a disability that the equipment is to assist. The program does not deliver, so the person picking up the equipment will need to come to a warehouse or satellite site to get the equipment. There are three parts to this form: Parts A, B, and C. Part A must be filled out by the Requestor. Parts B and C must be filled out by a health care professional treating the Beneficiary.

Part A: To be completed by the Requestor.

Person Requesting the Equipment (Requestor)

First Name*	Last Name*	
Street Address*		
City*	State*	Zip*
Phone*	Email Address	

Person Picking Up the Equipment (must be able to load and unload equipment independently)

<input type="checkbox"/> Same as Requestor Information above	First Name*	Last Name*	
	Street Address*		
	City*	State*	Zip*
	Phone*	Email Address	

Complete the printed form and mail, fax, or scan and email it to us at:

11701 Crain Highway, Cheltenham, MD 20623
 Fax: 240-230-8004 Email: dme.mdoa@maryland.gov

For office use only: Scanned: / /

Updated: 10/2025

Collection and Protection of Personal Information

Requestor and the health care professional are providing personal information (including, but not limited to, name, address, and date of birth) in this form. The purpose of requesting this personal information is to help operate, seek funding for, minimize costs of, and evaluate the DME Re-Use Program. Requestor, Beneficiary, and the pick-up person have a right to inspect, amend, or correct his/her personal information kept by the program. The program will not permit public inspection of the personal information, or make it available to others, except as permitted by federal and state law.

Liability Waiver and Release Agreement:

This agreement is a release of all rights to sue for injuries or death resulting from the equipment received from the nonprofit, state-operated Maryland Durable Medical Equipment Re-Use (hereinafter "MDMER"). The person requesting the equipment (hereinafter "Requestor") hereby expressly assumes all risks related in any way to the use or appropriateness of the equipment. Requestor understands MDMER: (i) does not provide medical advice on the appropriateness of any durable medical equipment; (ii) does not provide delivery service or post-delivery assembly, and (iii) does not recommend seeking advice of health professionals, such as physical therapists, occupational therapists, or nurse practitioners, before obtaining or using durable medical equipment. Requestor will examine the equipment to verify that the equipment is in good working order before the equipment is used to assist the beneficiary identified above (hereinafter "Beneficiary"). Requestor will read written and review video materials provided with the equipment and transmit the information contained therein to the Beneficiary and the Beneficiary's caregivers before the equipment is used. Requestor also understands that neither MDMER nor its officers, officials, agents, employees, or volunteers (hereinafter "Releasees") shall be held liable or responsible in any way for injury, death, or other damages to the Requestor, the Beneficiary, or the pick-up person, or their respective families, heirs, or assigns, that may result from or be related to in any way to the equipment, the use of the equipment, a product defect in the equipment, wear and tear of the equipment, or the passive or active negligence of any party, including the passive or active negligence of Releasees.

Requestor acknowledges that Requestor is accepting and taking ownership of the equipment "as is" and "with all faults," and acknowledges that MDMER has disclaimed all warranties. There is no warranty that the equipment will be fit for a particular purpose. Requestor acknowledges that Requestor assumes all risks resulting from the ownership and use of the equipment.

Requestor hereby releases, discharges, and agrees not to sue MDMER or any of the Releasees on account of any injury, loss, or damage of any kind (including, without limitation, death) to any person or property, caused directly or indirectly, or in any way arising out of the equipment, whether such injury or loss was caused or alleged to be caused in whole or in part by the passive or active negligence of the Releasees or otherwise.

Requestor shall hold harmless and indemnify the Releasees with respect to any claim of liability for any losses or damages allegedly caused by the equipment or its use.

MDMER MAY, IN ITS SOLE AND ABSOLUTE DISCRETION, DECLINE TO PROVIDE THE EQUIPMENT IF IT BELIEVES: 1) THE BENEFICIARY DOES NOT NEED THE EQUIPMENT OR 2) THE BENEFICIARY OR THE BENEFICIARY'S CAREGIVER(S) WILL NOT, OR WILL NOT BE ABLE TO, USE THE EQUIPMENT SAFELY.

I acknowledge that I have carefully read and fully understand the above liability waiver and release agreement and I affirm under the penalties of perjury that, to the best of my knowledge, information, and belief: (1) all the information I provided on this form is true and accurate, and (2) the equipment will only be for personal use and not sold.

Requestor's Signature:

Date:

Requestor's Printed Name:

Complete the printed form and mail, fax, or scan and email it to us at:

11701 Crain Highway, Cheltenham, MD 20623

Fax: 240-230-8004 Email: dme.mdoa@maryland.gov

Part B: To be completed by a licensed health care professional.

Equipment Beneficiary (must be a Maryland resident)			
First Name*		Last Name*	
Street Address*			
City*	County*	State*	Zip*
Phone*		Email Address	
Date of Birth*(MM/DD/YYYY)		Height*	Weight*
Beneficiary's Coverage (select all that apply): * <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> No Insurance		Why is DME not being purchased and paid for under the Beneficiary's insurance policy?*	

Part C: To be completed by a licensed health care professional.

Equipment Requested (Subject to availability):	
<p>Mobility Items</p> <p>Cane:</p> <input type="checkbox"/> Single Point <input type="checkbox"/> Quad Small Base <input type="checkbox"/> Quad Large Base <p>Crutches:</p> <input type="checkbox"/> Underarm <input type="checkbox"/> Forearm <p>Walker:</p> <input type="checkbox"/> Standard (no wheels) <input type="checkbox"/> Rolling (two wheels)	<p>Rollator</p> <input type="checkbox"/> Rollator <p>Bathing</p> <input type="checkbox"/> Shower Stool <input type="checkbox"/> Shower Chair with Back <input type="checkbox"/> Bathtub Transfer Bench <p>Toileting</p> <input type="checkbox"/> Bedside Commode <input type="checkbox"/> Toilet Safety Rails <p>Transfers</p> <input type="checkbox"/> Transfer Board
<p>Complex Devices Physician, PT, OT, PA, or CRNP ONLY:</p> <input type="checkbox"/> Manual Wheelchair <input type="checkbox"/> Transport Wheelchair <input type="checkbox"/> Knee Scooter <input type="checkbox"/> Semi/Electric Home Health Bed <input type="checkbox"/> Patient (Hoyer) Lift - Sling not Included <input type="checkbox"/> Trapeze Bar <p>Physical/Occupational Therapist ONLY</p> <input type="checkbox"/> Power Wheelchair <input type="checkbox"/> Power Scooter	<p>Additional Information/Requests:</p>
<p>Optimal Wheelchair:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Seat Width_____ <input type="checkbox"/> Seat Depth_____ <input type="checkbox"/> Joystick Left / Right 	
<p>I am a licensed health care professional _____* [insert profession] treating the above named beneficiary/patient within my scope of practice. The requested equipment is appropriate for the beneficiary/patient, and [choose one]:</p> <input type="checkbox"/> I or my staff will provide or have provided the necessary training on the identified equipment to the beneficiary/patient, their caregiver, or both, OR <input type="checkbox"/> The beneficiary/patient or caregiver is able to use the equipment safely without additional training.*	
Name*	Title*
License #*	Employer*
Phone*	E-mail Address*
Signature*	Date*

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