



## Medicaid Electronic Visit Verification (EVV) Small Alternative Device Order

**Provider Agency / FMSA Information Associated with Service Delivery to the Medicaid Individual/Member Named on Page 1**

Provider Agency / FMSA Legal Entity Name	MCO-SDA	Provider NPI or API	Provider TPI
DBA	Provider TIN		DADS 9 Digit Contract Number

**Certification**

My signature below certifies that I have the authority to sign Small Alternative Device Order Forms on behalf of the Provider Agency or FMSA identified above. I attest the information provided on this form is correct and complete. The Provider Agency, or individual receiving the device on behalf of the FMSA, agrees to (1) install the device in the Medicaid member's home, (2) return all nonfunctioning devices and devices that are no longer used to the appropriate vender, and (3) return all devices timely to the issuing EVV vendor upon termination of its affiliation with the issuing EVV vendor. (Consult your EVV Vendor for more information.)

Signature of Provider Agency Representative				Date
Title	(    )	AC	Phone	Email Address

**SHIPPING INFORMATION**

**Shipping Information for Provider Agency** (Non-Consumer Directed Services)

Provider Agency Name		
Street Address or PO Box	Bldg / Ste #	
City	State	Zip Code

**Provider Agency Contact for Shipment**

Name	
(    )	
AC	Phone
Email Address	

**Shipping Information for FMSA – Consumer Directed Services**

A device ordered for a person enrolled in CDS qualifies for direct delivery to an individual other than the Provider Agency or FMSA identified at the top of this order form. You are required to provide shipping information for a device ordered under the CDS model.

**Ship to:**

First Name	MI	Last Name
Street Address or PO Box	Unit or Apartment #	
City	State	Zip Code
(    )	Home Phone	(    )
AC		Alternate Phone