

Medicaid Provider ID: _____
or, Application Tracking Number (ATN)

Home Medical Equipment License Exemption Form

Chapter 400.93 F.S. requires any person or entity that holds itself out to the public as providing home medical equipment and services or accepts physician orders for home medical equipment and services, or any person or entity that holds itself out to the public as providing home medical equipment that typically requires home medical services must be licensed by the Agency for Health Care Administration to operate or provide home medical equipment and services in Florida unless they meet specific exemptions. A separate license is required of all home medical equipment providers operating on separate premises, even if the providers are operated under the same management.

All questions regarding HME licensure should be directed to the Agency's HME unit at (850) 414-6010.

Provider Name: _____
(Please print)

(Check the box that best describes your business.)

- Business that supplies **only diabetic monitors and disposable supplies**, e.g., diabetic, ostomy, urological or wound care supplies.
- Orthotics and prosthetic provider licensed under Chapter 468, part XIV, F.S., who sells **only orthotics and prosthetics**. *Submit a copy of your orthotics or prosthetics license with your Medicaid application.*
- DME business that is **owned by a pharmacy** licensed under Chapter 465, F.S. *Submit a copy of your pharmacy license with your Medicaid application.*
- DME business that is **owned by a nursing facility, assisted living facility, home health agency, hospice, intermediate care facility, home for special services, or transitional living facility** licensed under Chapter 400, F.S. *Submit a copy of your facility license with your Medicaid application.*
- DME business that is **owned by a hospital or ambulatory surgical center** licensed under Chapter 395, F.S. *Submit a copy of your facility license with your Medicaid application.*
- DME business that is **operated by the federal government**.

"I attest that my business meets the indicated exemption and therefore is not required to obtain a Home Medical Equipment (HME) license."

(Print Name of Authorized Signer)

(Title)

(Signature of Authorized Signer)

(Date)