TEXAS Health and Human Services

Form 4116-DME
August 2007-E

ICF/IID Durable Medical Equipment Summary Sheet

Facility Name	Billing Month	Contract Number

Client Name	Client Medicaid No.	DME Year Begin Date (MM/YYYY)	DME Year Cost Year-to-Date	Date Service Received	Receipt Date	DME Item/Service Description	Billing Code	Dollars Spent	Total Annual Cost Year-to-Date	DME Provider No.	Checklist			
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Contact Person	Contact Person's Telephone No.