

**Western Highlands Network
CAP MR/DD
Supply/Equipment Receipt and Authorization Confirmation Form**

To: Western Highlands Network
Attn: Accounting Department/Accounts Payable
356 Biltmore Avenue
Asheville, NC 28801
Fax: (828) 255-2774

From: _____

**Please complete the following information as proof of receipt of delivery and sign below
acknowledging receipt of delivery.**

Date of Delivery: _____

Time of Delivery: _____

Site/Address of Delivery: _____

Item(s) Delivered

Quantity

Consumer's Acknowledgement of Receipt

Consumer Name: _____

Consumer Signature: _____ Date: _____

Case Manager's Verification of Receipt and Authorization

The CAP-MR/DD Waiver requires prior approval for all services. I confirm the listed items received prior approval from Western Highlands and medical necessity is substantiated and documented in the consumer's record.

Case Manager Name: _____

Case Manager Signature: _____ Date: _____

Version: 07012006