DURABLE MEDICAL EQUIPMENT(DME)/MEDICAL SUPPLY
PRIOR AUTHORIZATION REQUEST

Please fax with supporting medical documentation to 800-882-6147.

REQUIRED DOCUMENTATION:

☐ DOCUMENTATION OF MEDICAL NECESSITY FROM THE TREATING PHYSICIAN
☐ A COPY OF THE SIGNED PRESCRIPTION

CLAIMANT FILE NUMBER: _____

CLAIMANT NAME: _____

DATE OF REQUEST: _____ CONTACT PERSON: _____

PROVIDER NAME: _____

PROVIDER NUMBER: _____ PROVIDER TAX ID: _____

PROVIDER ADDRESS: _____

PROVIDER FAX: _____ PROVIDER TELEPHONE: _____

ICD-9 DIAGNOSIS CODE(S)**(for dates of service 09/30/15 and prior): _____**

ICD-10 DIAGNOSIS CODES(S)**(for dates of service 10/1/15 and after): _____**

TREATING PHYSICIAN NAME: _____

Please indicate the cost for each item requested.

ITEM REQUESTED								
DESCRIPTON	**HCPCS/CPT CODE**	**MODIFIER**	**UNITS**	**PURCHASE**	**RENTAL**	**COST**	**DURATION OF NEED**	
							START DATE	**END DATE**
				☐	☐			
				☐	☐			
				☐	☐			
				☐	☐			
				☐	☐			