VA Premier Health Plan, Inc.

DURABLE MEDICAL EQUIPMENT (DME)
CERTIFICATE OF MEDICAL NECESSITY

This form is for prior authorization of durable medical equipment only. **ALL APPROVALS AUTHORIZED THROUGH THE USE OF THIS FORM ARE SUBJECT TO THE ENROLLEE'S BENEFITS AND ELIGIBILITY.**

Virginia Premier Health Plan, Inc
Contact us:
P.O. Box 5307 Richmond, VA 23220
Fax to Medical Management: 1-800-827-7192
For Medical Management questions call toll free: 1-888-251-3063
All other questions call toll free: 1-800-727-7536

_____ Patient's Date of Birth: _____/_____/_____
Patient's Name

Patient's ID# _____

_____
Patient's Address

_____ _____
City, State, Zip Code Telephone Number

Type of Equipment/Supply/Appliance:_____

Please describe the patient's condition that warrants the requested equipment (include the ICD-9 code): _____

What other treatment modalities have been tried in the past?

_____

What are your expected goals or outcomes for the patient?

_____

How long will the patient need the equipment/supply/appliance?

_____

Name/Phone Number of Preferred DME Vendor: _____ Phone #:_____

This Certificate of Medical Necessity has been sent to preferred DME Provider? _ ***Yes*** ***No***

Name of Ordering Physician_____ Telephone Number:_____

Physician's Address:_____

Physician's Signature: _____ Date: _____

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