

**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								
DESCRIPTION	HCPCS/CPT CODE	MODIFIER	UNITS	PURCHASE	RENTAL	COST	DURATION OF NEED	
							START DATE	END DATE