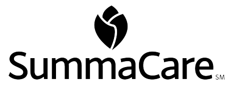

DURABLE MEDICAL EQUIPMENT PRIOR AUTHORIZATION REQUEST

Please fax to 234-542-0815

*For urgent request only, please call 330-996-8428 or 888-996-8428

HAS THE SERVICE BEING REQUESTED ALREADY BEEN PERFORMED? YES NO

Date____________________

Member Last Name____________________ First Name_______________________ MI____________

Member ID #_____________________________ Member DOB________________________________

Member Phone #____________________________

Start Date_________________ Set Up Date________________ Date Dispensed __________________

ORDERING PHYSICIAN

Last Name________________ First Name___________________ Tax ID #/ NPI #__________________

Address______________________________ City______________ State______ Zip________________

Phone #_________________________________ Fax #_______________________________________

Contact Name___________________________ Phone #______________________________________

BILLING PROVIDER INFORMATION

Provider Name____________________________ Provider Tax ID____________________

Physical Address (no P.O boxes)____

City, State, Zip___________________________________ Fax #_______________________

Contact Name______________________________ Contact Phone #____________________ Ext_____

Quantity	HCPCS	ICD-10 DX Code	Description	Rent/Purchase

CLINICAL INFORMATION– PERTINENT TO PROVIDER SERVICE (ATTACH COPIES OF PERTINENT CLINICALS)

Including letter of medical necessity and/or physician's orders, office notes, PT/OT notes, surgery report, patient demographics, and other documentation, if any.

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AUTHORIZATION #_________________________ CONTACT _________________________________