PHONE: 844-873-2905 FAX: 844-873-3163

# DME PRIOR AUTHORIZATION REQUEST FORM

*****Form must filled out completely and clinical information attached*****

| | | |
|---|---|---|
| Submitted by: (select one) ❑ Provider Office ❑ DME Supplier | | Today's Date: / / |
| Person to contact for this Submission: | | Phone: |
| **Patient's Name**: | **DOB:** | **Member ID**: |

| **Requesting Provider Information:** | **DME Supplier Information:** |
|---|---|
| NPI: | NPI: |
| Tax ID: | Tax ID: |
| Address: | Address: |
| Fax: | Fax: |
| Phone: | Phone: |

**Check one and complete the Date Range, below.**

| | | |
|---|---|---|
| ☐ | Proposed<br>Dates of Service | Services that have not yet been provided.<br>Purchase DME: Max 90 days. Rental DME: Max 13 months. |
| ☐ | Retro<br>Dates of Service | Services that have already been provided/started.<br>Purchase DME: Max 90 days. Rental DME: Max 13 months.<br>Retro requests must be submitted within 30 days from Date of Service. |

| | | |
|---|---|---|
| Date Range | From: | To: |

| **ICD-10 Code** | **Diagnosis Description** | **ICD-10 Code** | **Diagnosis Description** |
|---|---|---|---|
| 1. | | 3. | |
| 2. | | 4. | |

| **CPT/HCPCS Code** | **Rental or Purchase** | **Quantity for 90 days** |
|---|---|---|
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This request will be processed per the standard organization determination timeframes. If this request needs to be treated as "expedited", please note clinical justification why applying the standard timeframe for a determination could seriously **jeopardize the member's life, health or ability to regain maximum function:**

Authorization does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitation, provisions and exclusions. Please refer to www.healthteamadvantage.com for specific codes requiring a prior authorization.