Triad HealthCare Network Utilization Management

healthteam advantage

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DME PRIOR AUTHORIZATION REQUEST FORM

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

☐ **Purchase** ☐ **Initial Rental** ☐ **Additional Rental to existing auth #_____**

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:**
Name:	Name:
NPI:	NPI:
Tax ID:	Tax ID:
Address:	Address:
Fax:	Fax:
Phone:	Phone:

Check one and complete the Date Range, below.

☐	Proposed Dates of Service	Services that have not yet been provided. Purchase DME: Max 90 days. Rental DME: Max 13 months.	
☐	Retro Dates of Service	Services that have already been provided/started. Purchase DME: Max 90 days. Rental DME: Max 13 months. **INITIAL** Retro requests must be submitted within 7 days from the start date. **ADDITIONAL** rental requests must be submitted prior to start of new rental period.	
	Date Range	From:	To:

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

CPT/HCPCS Code	**Rental or Purchase**	**90 Day Quantity or # of Months of Rental**

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.