DME Prior Authorization FAX Request Form (Clinic/Vendor)

Quality and Utilization Improvement Dept.	Telephone # 1-(888) 467-0774
DME - Medical Policy	Fax # (952) 853-8714

Please complete ALL of the following.

Date: _____

Member Name:	Date of Birth:	Member #:

Ordering M.D.:_____

Clinic Clinic

Clinic:_____Phone #:_____ Fax #:_____

DX:_____ICD9 or ICD10:_____

Vendor Vendor

Vendor_____Phone #:_____ Fax #: _____

Tax ID#: _____ NPI#: _____

Form Completed by:_____Phone #:_____ Fax #:_____

Additional Comments: _____

_____

_____

_____

Rent for how long? _____ Purchase ____

NOTE: Attach medical necessity information

Has requested item been provided to member? Yes No (Please circle answer)
If yes, please provide date: _____

Equipment Request Information (Required if completed by vendor)

Item(s) Description	HCPC	Modifier	Cost	Start Date	End Date

VENDORS NOTE: Requests for prior authorization which are not submitted within 30 days of the date item was dispensed could be subject to denial (vendor liability).

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