FAX: 855-475-5614   PHONE: 833-523-2609

Prior Authorization DME Request Form

Date Requested: **Date of Service:**

<table>
<tr><td>☐ Standard Request</td><td>☐ Expedited Request

I Certify that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

Provider signature Required: ______________________________
Date__________</td></tr>
<tr><td>Patient Name:</td><td>Ordering Provider:</td></tr>
<tr><td>Patient Health Plan ID #</td><td>Service Provider:</td></tr>
<tr><td>Patient birthdate:</td><td>Contact Name:</td></tr>
<tr><td>ICD 10 Diagnosis:</td><td>Contact Phone: Fax:</td></tr>
<tr><td>Height: ____ Feet _____ Inches

Weight: ____ Lbs.</td><td>Complete only if ordering one of these items:
Platform Walker: ☐ Right ☐ Left

Air Cushion: Length: ___________ Width: ____________
Valves: ☐ Single ☐ Double

Profile: ☐ High ☐ Low

CPM: Full Leg Height_____ Speed____

Angular limits(degrees)______
Lymphedema Pump: Extremity:☐ Full Arm ☐Full Leg
☐Right ☐ Left ☐Both</td></tr>
<tr><td colspan="2">Check DME Type
☐ Purchase ☐ Rental: Rental Start date: ________________
Rental End date: _________________</td></tr>
</table>

Other DME		
Equipment	**HCPCS**	**Quantity**

Please fax completed form along with Supporting Clinical to include Physician Order and Letter of Medical Necessity to **855-475-5614** (Physician may sign below and it will be considered a valid order)

Physician Signature: ______________________________ Date_____________

05/2022