

**PRE-SERVICE/  
PRIOR AUTHORIZATION  
REVIEW REQUEST – DME**

Fax to Care Management:  
800-843-1114



**BLUE CROSS**

**HOME MEDICAL EQUIPMENT/PROSTHETICS/ORTHOTICS**

Request Date \_\_\_\_\_

**URGENT** – All requests marked as urgent/expedited must include supporting documentation from the physician’s office that the application of standard timeframes for making a non-urgent determination: (a) could seriously jeopardize the life or health of the patient or the ability to regain maximum function, or, (b) in the opinion of a physician with knowledge of the member's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment being requested.

MEMBER/PATIENT _____ Date of Birth _____	
Member ID _____ Suffix _____ Group # _____	
<b>REQUESTING PROVIDER</b> _____ Address _____ City/State/ZIP _____ Phone _____ Fax _____ <i>Optional information below – please include if known.</i> Contact Person _____ Tax ID/NPI # _____ Contracted Provider: <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>SERVICING PROVIDER</b> _____ Address _____ City/State/ZIP _____ Phone _____ Fax _____ <i>Optional information below – please include if known.</i> Contact Person _____ Tax ID/NPI # _____ Contracted Provider: <input type="checkbox"/> Yes <input type="checkbox"/> No

PRESCRIPTION AND DOCUMENTATION OF MEDICAL NECESSITY REQUIRED	
ICD Diagnosis _____	Facility Name _____
Provider comments _____	
Existing Reference # _____	Expiration Date _____

HCPCS Code	Requested Item	Quantity/ Length of Supply	Purchase Price	Rental Fee	Length of Rental

Anticipated Delivery Date \_\_\_\_\_

**Note:** Unless specifically requested elsewhere in this document, do not send a DNA or other genetic sample, or the results of any genetic typing, test, or analysis, including DNA.  
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