

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

PBC fax to: 800-843-1114  
FEP fax to: 866-948-8823  
**(Handwritten faxes not  
accepted.)**



**HOME MEDICAL EQUIPMENT/PROSTHETICS/ORTHOTICS**

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

MEMBER/PATIENT _____ Date of Birth _____	
Member ID _____	Suffix _____ Group # _____
<b>REQUESTING PROVIDER:</b> _____ Address: _____ City/State/ZIP: _____ Phone: _____ Fax: _____ Contact person: _____ Tax ID <b>(required)</b> : _____ NPI # (if available): _____	<b>SERVICING PROVIDER:</b> _____ Address: _____ City/State/ZIP: _____ Phone: _____ Fax: _____ Contact person: _____ Tax ID <b>(required)</b> : _____ NPI # (if available): _____

**URGENT REQUEST**

**PLEASE NOTE: Scheduling issues do not meet the definition of urgent.**

Urgent requests must be signed and include supporting documentation from the provider's office, noting that standard timeframes for making a non-urgent determination could:

- Seriously jeopardize the life/health of the patient or the ability to regain maximum function, **or**
- Seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, **or**
- In the opinion of a provider with knowledge of the member's medical or behavioral condition, subject the patient to adverse health consequences without the requested care or treatment.

**I attest that this request meets the urgent definition described above: MD signature:** \_\_\_\_\_

ICD Diagnosis Codes \_\_\_\_\_

HCPCS Code	Requested Item	Quantity	Purchase Price	Or Rental Fee	Length of Rental

**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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