PRE-SERVICE/
PRIOR AUTHORIZATION
REVIEW REQUEST – DME

Fax to Care Management:
800-843-1114

PREMERA | 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 # _____

REQUESTING PROVIDER _____	**SERVICING PROVIDER** _____
Address _____	Address _____
City/State/ZIP _____	City/State/ZIP _____
Phone _____ Fax _____	Phone _____ Fax _____
Optional information below *– please include if known.*	***Optional information below*** *– please include if known.*
Contact Person _____	Contact Person _____
Tax ID/NPI # _____	Tax ID/NPI # _____
Contracted Provider: ☐ Yes ☐ No	Contracted Provider: ☐ Yes ☐ 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.