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

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

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

## HOME MEDICAL EQUIPMENT/PROSTHETICS/ORTHOTICS

**Request Date** _____
**Anticipated Delivery Date** _____

| | |
|---|---|
| **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: _____ |
| Contact person: _____ | Contact person: _____ |
| Tax ID (**required**):_____ | Tax ID (**required**):_____ |
| NPI # (if available): _____ | 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 |
|---|---|---|---|---|---|
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**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.