

**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 # _____ |
| REQUESTING PROVIDER: _____ Address: _____ City/State/ZIP: _____ Phone: _____ Fax: _____ Contact person: _____ Tax ID (required) : _____ NPI # (if available): _____ | SERVICING PROVIDER: _____ Address: _____ City/State/ZIP: _____ Phone: _____ Fax: _____ Contact person: _____ Tax ID (required) : _____ 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.
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