



# Durable Medical Equipment Prior Approval Request Form

### Disclaimer Statements and Attestation

Prior Approvals will be given for medically necessary services only: it is not a guarantee of payment. Payment is subject to verification of member eligibility and to the limitations and exclusions of the member's contract.

### MEMBER INFORMATION

Member ID#:	Last Name:	First Name:
Phone Number:	Date of Birth:	Gender:    M    F
Street Address:	City, State, Zip:	
Is Member Being Discharged From an Inpatient Facility?                      Yes                      No		

### ORDERING PHYSICIAN INFORMATION

Ordering Physician Name:	Ordering Physician NPI Number:
Ordering Physician Phone Number:	Ordering Physician Fax Number:

### DME PROVIDER INFORMATION

DME Provider Name:	NPI Number:
Street Address:	City, State, Zip:
Phone Number:	Fax Number:

### REQUEST FOR SERVICES

Request Date:	Expected Delivery Date of DME:
---------------	--------------------------------

### DESCRIPTION OF DME ITEMS NEEDED

HCPCS Code:	Number of Units:	Description:
HCPCS Code:	Number of Units:	Description:
HCPCS Code:	Number of Units:	Description:
Additional Codes:		

Type of request:	Initial Device rental	Continued Rental	Replacement	Purchase
------------------	-----------------------	------------------	-------------	----------

If Continued Rental, Date DME Delivered:	If Continued Rental, Date of Service:
--	---------------------------------------

Primary ICD10 Code(s):			
------------------------	--	--	--

### CONTINUITY OF CARE INFORMATION

Effective Date of Insurance:	Initial Start Date of Rental Period:
Start Date of Current Authorization:	End Date of Current Authorization:
Months Left on Capped Rental:	

### RETROACTIVE REQUEST INFORMATION

Is this a Retroactive Request?	Yes	No	Delivery Date:
--------------------------------	-----	----	----------------

To request Prior Approvals for DME, log onto [www.evicore.com](http://www.evicore.com) for online submissions, or fax all of the following documents to 866-663-7740

1. This completed form
2. Current physician's order/script
3. Current detailed invoice listing all requested equipment (if required)
4. Current clinical related to request (i.e., patient history, progress notes and physical exams)

**Call 866-417-2345 (options 3,4) to speak with an eviCore healthcare representative**

CONFIDENTIALITY NOTICE: This fax transmission, and any documents attached to it may contain confidential or privileged information subject to privacy regulations such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This information is intended only for the use of the recipient(s) named above. If you are not the intended recipient, or a person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of any of the information contained in or attached to this transmission is STRICTLY PROHIBITED. If you have received this transmission in error, please immediately notify me and destroy the original transmission and its attachments without saving them in any manner.