

Prior Authorization Form Durable Medical Equipment/ Wheelchair Request



Phone: 1-800-521-6622 | Fax: 1-866-755-9841

Contact name:

Phone number:

Fax number:

Member information	
Member name:	Member ID number:
Date of birth:	Member's phone number:
Authorization number, if applicable:	
Primary insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of carrier:
Primary insurer member ID:	Primary authorization number:

Provider information	
Physician name:	Physician NPI:
Physician phone number:	Physician fax number:
DME vendor name:	DME vendor NPI:
DME vendor phone number:	DME vendor fax number:

Codes					
ICD diagnosis code	HCPC code	Dates of service	Units/month	Purchase/rental	Billing amount

Wheelchair/powered vehicle
<p>Please note: Home assessment is necessary for all manual wheelchairs, power wheelchairs, and scooters. DHS Prescription form for Motorized Wheelchairs is necessary for all power wheelchair and scooter requests.</p>
<p>Additional information:</p>

CLINICAL NOTES TO SUPPORT THE MEDICAL NEED OF THIS SERVICE ARE REQUIRED, TO INCLUDE A CURRENT SCRIPT THAT LISTS FREQUENCY AND DURATION. SCRIPTS NEED TO BE UPDATED EVERY SIX MONTHS.

ALL FIELDS MUST BE COMPLETED FOR REQUEST TO BE PROCESSED.