DME/ORTHOTICS/PROSTHETICS PRIOR AUTHORIZATION REQUEST

IF NOT COMPLETED IN FULL, REQUEST WILL BE RETURNED

Phone: 888-961-3100 Fax: 888-465-5581

Your request ***MUST*** include ***Physician's Order*** and ***Documentation of Medical Necessity*** (Hx, Previous Tx, Consult evals, Rehab Evals and Tests) to be processed.

MEDICAL EQUIPMENT REQUESTS

Member Name: _____
(Last) (First) (Middle)

DOB: ___ /___ /____ **Ph #:** _____ **Guardian (if applies)**: _____

Member Address: _____

City: _____ **State** _____ **Zip** _____

Alternate Contact Name: _____ **Ph#:**_____

Member RID #:_____

PMP Name: _____ **Ph#:** _____

Ordering Physician Name: _____ **Ph#:** _____

SERVICING PROVIDER NAME: _____

Ph #: (_____) _____ **Fax #:** (_____) _____

PERSON Completing Form: _____ **IHCP #** _____

Ph #: (_____) _____ **Fax #:** (_____) _____

Diagnosis (ICD9) **code(s)** _____

Please Complete The Appropriate Areas Below: (if not complete, it may be returned)

DME/HCPCS	Description of Equipment	# units	From date	To date	P: purchase R: rental

THIS BOX FOR MDwise Hoosier Alliance USE ONLY

Form Received: ____ / _____ / ____

Case Manager Opening Case

_____

Date Medical Info Requested:

_____ / _____ / _____

Date *all necessary* **Medical Information Received:**

_____ / _____ / _____

Date Sent to **Physician/Reviewer:**

_____ / _____ / _____

Physician/Reviewer's Decision:

- ❑ **APPROVED**
- ❑ **APPROVED AS MODIFIED**
- ❑ **DENIED**
- ❑ **PENDED for further information**

Date of Decision:

_____ / _____ / _____

Physician/Reviewer's Signature:

_____

Tracking #: _____

Authorization#:_____

Denial #: _____

Denial Letter Sent/Faxed: _____ / _____ / _____

☐ Patient ☐ PMP

☐ Requesting Provider

Servicing Provider Notes/Comments: _____

_____

SPACE BELOW IS FOR MDwise Hoosier Alliance USE ONLY

Notes/Comments: _____

_____

YOU WILL RECEIVE A RESPONSE TO ALL ROUTINE REQUESTS WITHIN 2 BUSINESS DAYS FOLLOWING RECEIPT OF ALL NECESSARY MEDICAL INFORMATION. QUESTIONS/CALL: 888-961-3100

Prior Authorization is not a guarantee of payment: Please be sure to check eligibility.

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