



# HEALTH BENEFIT PLAN



20547 Waverly Court, Ashburn, Virginia 20149

Brian L. Renfroe, President • Stephanie M. Stewart, Director

## Durable Medical Equipment (DME) Prior Authorization Form

**Fax: 703-729-8128**

<input type="checkbox"/>	<b>Standard Request</b>	Requests for prior authorization (with supporting clinical information and documentation) should be sent to the Health Plan a minimum of fourteen (14) days prior to the date the requested services will be performed.
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<b>Physician Signature Validating Request</b>	<b>Date Signed</b>
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### MEMBER INFORMATION

<b>Last Name</b>		<b>First Name</b>	
<b>Member ID</b>		<b>DOB</b>	
<b>Member Address</b>			
<b>Member Contact Information</b>			

### ORDERING PHYSICIAN INFORMATION

<b>Last Name</b>		<b>First Name</b>	
<b>NPI</b>		<b>Tax ID</b>	
<b>Group Name</b>			
<b>Address</b>			
<b>Phone</b>		<b>Fax</b>	

### VENDOR PROVIDING DME

<b>Vendor Name</b>			
<b>Address</b>			
<b>Phone</b>		<b>Fax</b>	
<b>NPI</b>		<b>Tax ID</b>	

### BILLING CODE INFORMATION (Attach supplemental documents is necessary)

<b>Purchase</b>	Y <input type="checkbox"/> N <input type="checkbox"/>	<b>Rental</b>	Y <input type="checkbox"/> N <input type="checkbox"/>	<b>Initial Request</b>	Y <input type="checkbox"/> N <input type="checkbox"/>	<b>Replacement</b>	Y <input type="checkbox"/> N <input type="checkbox"/>
<b>HCPC/CPT Code</b>	<b>Code Description</b>	<b>Start Date</b>	<b>End Date</b>	<b>Number of Units and Cost</b>			

**Important: The Plan requires a letter of medical necessity, or a copy of the prescription, from the prescribing physician which details the medical necessity to consider charges for the purchase or rental of DME. Please submit supportive clinical documentation to substantiate the need for DME including but not limited to: H&P, office notes, laboratory and imaging results, and skilled therapy reports.**

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