

# Notification Form

Fax Form To: 616 942-0024 – Attn: Medicaid Department



## Oxygen Therapy and Apnea Monitors

(To be used for PriorityMedicaid members under 21 years of age)

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### Member

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

ID #: \_\_\_\_\_ DOB: \_\_\_\_\_

Diagnosis/Condition: \_\_\_\_\_

Request is for:  Oxygen Therapy  Apnea Monitor

### Requesting Provider Information:

Provider Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ Contact Name: \_\_\_\_\_

\_\_\_\_\_ Date of Request: \_\_\_\_\_

### Requesting DME Provider Information:

Company Name: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Extension: \_\_\_\_\_

### Notification Process for Oxygen Therapy and Apnea Monitors:

1. Vendor receives an order for oxygen therapy or an apnea monitor for a PriorityMedicaid member under 21 years of age.
2. Vendor will complete this notification form and fax it to 616 942-0024.

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