

# Prior Authorization Form

Fax Form To: 616 942-0024



## DME / P & O

### Member:

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

Priority Health ID #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Requested By:

Ordering Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

Diagnosis (description): \_\_\_\_\_ Diagnosis Code(s): \_\_\_\_\_

Requested Date Span From: \_\_\_\_\_ To: \_\_\_\_\_

Purchase  Rental (Length of need must be on Rx from physician)

### Directed To (DME Provider Information):

Provider Name: \_\_\_\_\_ Provider Tax ID: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

### Mandatory Documentation for Prior Authorization

- Complete description and medical necessity for NOC codes
- Copy of physician's order with supporting documentation to show medical necessity
- Repairs as follows:
  - Medicaid greater than \$500
  - HMO, POS, Medicare >\$1,000
  - ASO > \$1,000 (Check to see if specific group covers)
- Prosthetics: K level \_\_\_\_\_
- Date similar item last received: \_\_\_\_\_
- Mobility devices: Provide answers to medical necessity according to InterQual®

Quantity	Procedure Code	Make/Model	Description	Retail	R/P

To facilitate prompt and accurate processing, the information above must be complete and all supporting clinical documentation related to this request **MUST** be submitted with this form.