Fax completed form to **888.647.6152** Questions? Call our Provider Helpline at 800.942.4765. Priority Health

DME / P&O prior authorization form

☐ Check if requesting on behalf of a Cigna-participating provider
☐ Check if your request is a Medicare Pre-Service Organization Determination (PSOD)

Date of request: _____

Member information

Member last name		Member first name	
Priority Health ID#		Date of birth	

Requested by

Ordering physician		Ordering physician NPI	
Phone		Fax	
Address		Diagnosis code(s)	
		Diagnosis (description)	
Requested date span	From:	To:	
Request type – *length of rental must be on Rx*	☐ Purchase	☐ Rental	
Request priority	☐ Standard	☐ Expedited*	

**By checking this box, I attest that the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.*

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 greater than $1,000
  - ASO greater than $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, accurate processing, the information above must be complete and all supporting clinical documentation related to this request MUST be submitted with this form.

Print