group health Cooperative of eau claire

Request Form

DME Authorization

Patient's Name: _____ DOB: _____ ID# _____

Prescribing Provider: _____ Tax ID: _____ Fax# _____
Name/Clinic

DME Provider: _____ Tax ID: _____ NPI: _____

Phone: _____ Fax: _____

Diagnosis: _____ ICD-10: _____

DME Item 1: _____ HCPCS: _____

☐ Purchase ☐ Rental Start Date _____ End Date _____

DME Item 2: _____ HCPCS: _____

☐ Purchase ☐ Rental Start Date _____ End Date _____

DME Item 3: _____ HCPCS: _____

☐ Purchase ☐ Rental Start Date _____ End Date _____

DME Item 4: _____ HCPCS: _____

☐ Purchase ☐ Rental Start Date _____ End Date _____

Please submit clinical documentation to support medical necessity for requested item.

Please indicate if any of the following is suspected to be a cause of the indicated need for the service:

☐ MVA ☐ Liability ☐ Workers' Compensation ☐ Indicate if this is an emergent request

Please note: In the case of an emergent medical need for a service event authorized service, a service event request with clinical justification of the emergent need must be faxed to the Health Management Department as soon as possible before the services are performed. Please indicate on your request the need for an emergent review.

Provider Contact Name	Phone #	Fax #	Date

Please refer to the Provider Manual for specific information regarding the need for service event authorizations.

Privacy and Confidentiality:
The information within this fax message is intended for the recipient(s) only. If you have received this fax in error, please contact us at (715) 552-4300 and destroy this document received. State and Federal Law prohibits any unauthorized use of this information. Thank you for your cooperation.