



DME Prior Authorization Request

Member Information		
Member Name (please print)	Date of Birth	Member ID

Provider Information			
Prescribing Provider		Tax ID	Fax
DME Provider		Tax ID	NPI
Provider Contact Name	Phone	Fax	Request Date
Diagnosis			ICD-10
DME Item 1			HCPCS
<input type="checkbox"/> Purchase	<input type="checkbox"/> Rental	Start Date	End Date
DME Item 2			HCPCS
<input type="checkbox"/> Purchase	<input type="checkbox"/> Rental	Start Date	End Date
DME Item 3			HCPCS
<input type="checkbox"/> Purchase	<input type="checkbox"/> Rental	Start Date	End Date
DME Item 4			HCPCS
<input type="checkbox"/> Purchase	<input type="checkbox"/> Rental	Start Date	End Date
Please submit clinical documentation to support medical necessity for requested item.			

Please indicate if any of the following apply:
<input type="checkbox"/> MVA <input type="checkbox"/> Liability <input type="checkbox"/> Worker's Compensation

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Please fax completed form to: Group Health Cooperative of Eau Claire **Fax:** 715.552.7202