group health Cooperative of eau claire

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	
☐ 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 apply:
☐ MVA ☐ Liability ☐ Worker's Compensation

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