

Two Chase Corporate Drive, Suite 300
Hoover, AL 35244
205-423-1222 or 1-800-962-3018
FAX: 205-444-4284



POWER MOBILITY DEVICE REQUEST

PROVIDER INFORMATION

PROVIDER NAME:
CONTACT:
PHONE:
FAX:
DATE OF SERVICE: FROM _____ TO _____
DIAGNOSIS: _____ ICD-9 _____
ORDERING PHYSICIAN: _____ (print first and last name)

MEMBER INFORMATION

NAME:
POLICY#:
DOB:
PREVIOUS AUTH#

*****MD ORDER REQUIRED TO PROCESS*****

Other Equipment:

Equipment _____	HCPS Code _____	Cost _____
Equipment _____	HCPS Code _____	Cost _____
Equipment _____	HCPS Code _____	Cost _____
Equipment _____	HCPS Code _____	Cost _____

Checklist:

- Member or Provider initiated the request on _____ date
- Face to Face _____ date (include copy)
- Detailed order/product description signed by MD
- PT Evaluation
- Home assessment

Please submit required supporting documentation.

Repairs:

Date device was purchased: _____

Equipment _____	HCPS Code _____	Cost _____
Equipment _____	HCPS Code _____	Cost _____
Equipment _____	HCPS Code _____	Cost _____
Labor units _____	HCPS Code _____	Cost _____

Authorization number: _____ Dates: _____
Contact: _____ Phone: _____

This authorization is for medical necessity only and not a guarantee of payment. Eligibility is determined at the time the claim is received and benefits are subject to the limitations and exclusions of the member's plan.