

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



DURABLE MEDICAL EQUIPMENT REQUEST

PROVIDER INFORMATION

MEMBER INFORMATION

PROVIDER NAME:
CONTACT:
PHONE:
FAX:
DATE OF SERVICE: FROM _____ TO _____
DIAGNOSIS: _____ ICD-9 _____
ORDERING PHYSICIAN: _____

NAME:
POLICY#:
DOB:
PREVIOUS AUTH#

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

Oxygen Therapy

____ Concentrator HCPS Code _____ (CMN required in 6 mos)
____ Portable HCPS Code _____
____ Liquid O2 Stationary HCPS Code _____
____ Liquid O2 Portable HCPS Code _____

****O2 Saturation level _____ (Required for new setup)
____ CPAP(E0601) HCPS Code _____ (Sleep study required)
____ BIPAP(E0470) HCPS Code _____ (Must submit
sleep study results and documented
CPAP failure)

____ Humidifier HCPS Code _____
____ CPAP/BIPAP set up kit HCPS Code _____

Other Equipment:

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

Enteral Feeding: (Must submit CMN within 30 days)

Formula _____ HCPS Code _____ #of cans _____ Cost _____
Item(s) requested _____ HCPS Code _____ Cost _____
Type of Feeding: [] Bolus Feed [] Gravity Feed [] Pump
Amount of nutrition formula is providing _____ %/ml per day

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.

Additional information may be required using DMERC criteria.