Durable Medical Equipment
Please Fax to:
PRE-AUTH: 866-603-5534
or
ASO/CMR: 866-603-5536

DATE ______________ OFFICE CONTACT ________________________________

PHONE ________________________ FAX __________________________

REQUESTING PHYSICIAN ____

PATIENT NAME _________________________ ID # ________________ DOB _____________

VENDOR NAME ____

ITEMS REQUESTED ____

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DIAGNOSIS/ICD 9 ____

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HCPCS CODE ____

AUTH # ___________ EFFECTIVE DATES ______________ ENTRY INITIALS ____________

REASON FOR REQUEST (WHAT WILL THE DME / ORTHOSIS BE USED TO ACCOMPLISH):

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*** Please include a signed doctor's order or letter of medical necessity***

7/13/2005