**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 ______________________________________________________

______________________________________________________

DIAGNOSIS/ICD 9 _____________________________________________

_____________________________________________

_____________________________________________

HCPCS CODE _____________________________________________

AUTH # ____________ EFFECTIVE DATES _______________ ENTRY INITIALS _____________

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

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

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

7/13/2005