Partners Health Plan

PHP CARE COMPLETE FIDA-IDD PLAN's DME POS REQUEST FORM

Participant Name: _____Participant ID #: 450000_ _ _ _ _ _ _ (fill in last 7 digits)
Sex: _____ DOB: _____ Phone Number: (___) _____Address:
_____ County of
Residence: _____ Participant Representative: _____
Phone Number: (___) _____Address:
_____
Participant PHP Care Manager: _____ Phone: (_____) _____

Requesting Provider Name: _____ NPI: _____
Address: _____
Phone Number: (___) _____Extension: _____

Contact Name (person completing form): _____
Phone Number: (___) _____ Extension: _____

DME -POS Being Requested: _____
HCPCS: _____
Pertinent Diagnosis Code (s): _____
Pertinent Diagnosis Description:
_____

Please fax completed form, along with SCRIPT, LETTER OF MEDICAL NECESSITY and CLINICAL DOCUMENTATION to: 646-892-4810 For questions, please call 855-747-5483