PHP CARE COMPLETE FIDA-IDD PLAN
DME Prior Authorization Request Form

Patient Information

Name (First, MI, Last):	DOB:	Member ID Number: Fill in last 7 digits 450000_ _ _ _ _ _ _
Address:		
Guardians Name:	Telephone Number:	

DME Vendor: ☐ In Network ☐ Out of Network	Phone Number	Fax Number:
Address:	Tax ID Number	NPI Number:
Prescribing Physician: ☐ In Network ☐ Out of Network	Phone Number:	Fax Number:
Address:	Tax ID Number:	NPI Number:

Authorization Request Information Urgency: ☐ Urgent ☐ Standard ☐ Hospital Discharge

Service Start Date _____/_____ / _____ Service End Date ____/ ____/_____

CPT/HCPCS CODE(S)	CPT/HCPCS CODE DESCRIPTION(S)	# UNITS REQUESTED	ICD-10 DIAGNOSIS CODE(S)	DIAGNOSIS DESCRIPTION(S)

Please contact 646-455-1594 for DME related questions

Send completed form and supplemental clinical to fax number 646-948-1027

Incomplete forms or lack of supplemental clinicals can result in the delay of case set up and processing.