

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:	

Requesting Provider: <input type="checkbox"/> In Network <input type="checkbox"/> Out of Network	Phone Number	Fax Number:
Address:	Tax ID Number	NPI Number:
Treating Facility: <input type="checkbox"/> In Network <input type="checkbox"/> Out of Network	Phone Number:	Fax Number:
Address:	Tax ID Number:	NPI Number:

Provider Information

Contact Name (person completing this form):	Phone/Fax Number:	Represent: (check one) <input type="checkbox"/> Provider <input type="checkbox"/> Facility
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Authorization Request Information

Check one: Inpatient Outpatient DME

Service Start Date ___/___/___ Service End Date ___/___/___

CPT/HCPCS CODE(S)	CPT/HCPCS CODE DESCRIPTION(S)	# VISITS/DAYS/ UNITS REQUESTED	ICD 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.