



DME/Medical Supply Request Form

Fax: (602) 778-3331

Phone: (602) 778-3330
1-866-406-0955

Date of Request: \_\_\_\_\_

[ ] Routine

[ ] Urgent

Member Name: \_\_\_\_\_ ID#: \_\_\_\_\_ DOB: \_\_\_\_\_

Dates of Service: From: \_\_\_\_\_ Through: \_\_\_\_\_ Diagnosis (ICD-9 Code): \_\_\_\_\_

Ordering Physician: \_\_\_\_\_ Telephone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Table with 8 columns: HCPC Code, Description of Ordered Product, Medicare Covered? Y or N, Excess Quantity Ordered, Ordered Quantity, Medicare Covered Quantity, ALTCS Covered Benefit? Y or N, SCAN Contracted Price

Comments (if possible please fax in supporting documentation with request): \_\_\_\_\_

Requesting Vendor : \_\_\_\_\_ Telephone Number/EXT: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Fax #: \_\_\_\_\_ Date: \_\_\_\_\_

HEALTH PLAN USE ONLY

Approved [ ]

Authorization Number: \_\_\_\_\_ Valid From: \_\_\_\_\_ to \_\_\_\_\_ Expiration Date

Denied [ ] Denial Reason: \_\_\_\_\_

Medical Director Signature

PA Nurse/Tech Signature

Date

Please fax form to DME Vendor