



**DME/ORTHOTICS/PROSTHETICS PRIOR AUTHORIZATION REQUEST**  
 IF NOT COMPLETED IN FULL, REQUEST WILL BE RETURNED

Phone: 888-961-3100 Fax: 888-465-5581

Your request **MUST** include **Physician's Order** and **Documentation of Medical Necessity** (Hx, Previous Tx, Consult evals, Rehab Evals and Tests) to be processed.

**MEDICAL EQUIPMENT REQUESTS**

<p><b>Member Name:</b> _____          (Last) (First) (Middle)</p> <p><b>DOB:</b> ___/___/___ <b>Ph #:</b> _____ <b>Guardian (if applies):</b> _____</p> <hr/> <p><b>Member Address:</b> _____</p> <p><b>City:</b> _____ <b>State</b> _____ <b>Zip</b> _____</p> <p><b>Alternate Contact Name:</b> _____ <b>Ph#:</b> _____</p> <hr/> <p><b>Member RID #:</b> _____</p> <p><b>PMP Name:</b> _____ <b>Ph#:</b> _____</p> <p><b>Ordering Physician Name:</b> _____ <b>Ph#:</b> _____</p> <p><b>SERVICING PROVIDER NAME:</b> _____</p> <p><b>Ph #:</b> ( _____ ) <b>Fax #:</b> ( _____ )</p> <p><b>PERSON Completing Form:</b> _____</p> <p><b>Ph #:</b> ( _____ ) <b>Fax #:</b> ( _____ )</p> <hr/> <p><b>Diagnosis (ICD9) code(s)</b> _____</p> <p><b>Please Complete The Appropriate Areas Below:</b> (if not complete, it may be returned)</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:10%;">DME/HCPCS</th> <th style="width:40%;">Description of Equipment</th> <th style="width:10%;"># units</th> <th style="width:10%;">From date</th> <th style="width:10%;">To date</th> <th style="width:10%;">P: purchase R: rental</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> <hr/> <p><b>Servicing Provider Notes/Comments:</b> _____</p> <hr/> <p><b>*SPACE BELOW IS FOR MDwise Hoosier Alliance USE ONLY*</b></p> <p><b>Notes/Comments:</b> _____</p>	DME/HCPCS	Description of Equipment	# units	From date	To date	P: purchase R: rental																																																							<p align="center"><b>*THIS BOX FOR MDwise Hoosier Alliance USE ONLY*</b></p> <p><b>Form Received:</b> ___/___/___</p> <p><b>Case Manager Opening Case</b></p> <hr/> <p><b>Date Medical Info Requested:</b></p> <p>___/___/___</p> <p><b>Date <u>all necessary</u> Medical Information Received:</b></p> <p>___/___/___</p> <p><b>Date Sent to Physician/Reviewer:</b></p> <p>___/___/___</p> <p><b>Physician/Reviewer's Decision:</b></p> <p><input type="checkbox"/> APPROVED</p> <p><input type="checkbox"/> APPROVED AS MODIFIED</p> <p><input type="checkbox"/> DENIED</p> <p><input type="checkbox"/> PENDED for further information</p> <p><b>Date of Decision:</b></p> <p>___/___/___</p> <p><b>Physician/Reviewer's Signature:</b></p> <hr/> <p><b>Tracking #:</b> _____</p> <p><b>Authorization#:</b> _____</p> <p><b>Denial #:</b> _____</p> <p><b>Denial Letter Sent/Faxed:</b> ___/___/___</p> <p><input type="checkbox"/> Patient    <input type="checkbox"/> PMP</p> <p><input type="checkbox"/> Requesting Provider</p>
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YOU WILL RECEIVE A RESPONSE TO ALL ROUTINE REQUESTS WITHIN 2 BUSINESS DAYS FOLLOWING RECEIPT OF ALL NECESSARY MEDICAL INFORMATION. QUESTIONS/CALL: 888-961-3100

*Prior Authorization is not a guarantee of payment: Please be sure to check eligibility.*

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