

# IUMG DME Prior Authorization Request Form

Fax to: 317-860-2734 or 317-860-2735

## MEDICAL EQUIPMENT REQUESTS

MDwise Wishard

**\*\*\*NOTE: Your Request Must Include Physician's Order and Documentation of Medical Necessity to be Processed\*\*\***

<p><b>Member Name:</b> _____  <small>(Last) (First) (Middle)</small></p> <p><b>DOB:</b> ___/___/___ <b>Ph #:</b> _____ <b>Guardian Name:</b> _____</p> <p><b>Address:</b> _____</p> <p><b>City:</b> _____ <b>State</b> _____ <b>Zip</b> _____</p> <p><b>Alternate Contact Name:</b> _____ <b>Ph#:</b> _____</p> <p><b>Medicaid RID #:</b> _____</p> <p><b>PCP 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> <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; text-align: center;"> <thead> <tr> <th style="width: 10%;">DME/HCPCS</th> <th style="width: 30%;">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: purch R: rent.</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> <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> <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>	DME/HCPCS	Description of Equipment	# units	From date	To date	P: purch R: rent.																																																																																																																									<p style="text-align: center;"><b>*THIS BOX FOR IUMG USE ONLY*</b></p> <p><b>Form Received:</b> ___/___/___</p> <p><b>Case Manager Opening Case</b></p> <p>_____</p> <p><b>Date Medical Info Requested:</b></p> <p>___/___/___</p> <p><b>Date <i>all necessary</i> 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/MODIFIED</p> <p><input type="checkbox"/> DENIED</p> <p><input type="checkbox"/> PENDED for further inform</p> <p><b>Date of Decision :</b></p> <p>___/___/___</p> <p><b>Physician/Reviewer's Signature:</b></p> <p>_____</p> <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"/> PCP</p> <p><input type="checkbox"/> Requesting Provider</p>
DME/HCPCS	Description of Equipment	# units	From date	To date	P: purch R: rent.																																																																																																																										
<p><b>Servicing Provider Notes/Comments:</b> _____</p> <p>_____</p> <p><b>MM Notes/Comments:</b> _____</p> <p>_____</p>																																																																																																																															

**YOU WILL RECEIVE A RESPONSE TO YOUR FAX WITHIN 48 HOURS  
 ONCE ALL MEDICAL DOCUMENTATION IS RECEIVED**

**QUESTIONS/CALL: 317-860-2736**

*Prior Authorization is Not a Guarantee of Payment.*

Edited 01.01.2010