Health Partners Plans

DME Authorization Request Form

DME Fax Information	
To: HPP DME **Medicaid Fax # (215) 849 – 4749** **Medicare Fax # (267) 515 – 6636**	**DME Provider Name:**
	DME PROMISe ID #:
DME Contact:	**DME Phone #:**
Date: _____ / _____ / _____	**DME Fax #:**

Provider – Please Complete Area Below		
Member Name:	**Member ID #:**	**Member's DOB:** _____ / _____ / _____
Dates of Service Requested: _____ / _____ / _____	**Duration of Service:**	
ICD 10/Diagnosis:	**Description: (Description of medical condition/diagnosis)**	
Ordering Physician Name:	**Phone #**	
PROMISe ID #:	**Fax #**	

Attachments (Supporting the Requested Clinical Service):

- ☐ Physician-signed Prescription
- ☐ Letter of Medical Necessity (LMN)
- ☐ DME Manufacturer's Invoice (if applicable)

AUTHORIZATION WILL BE DENIED WITHOUT DOCUMENTATION OF MEDICAL NECESSITY *and* PROMISe ID

Specifics of Request: E.g., volume, frequency, route, total number units. Note: Use **NU** or **RR** modifier as required.

Please complete the HCPCS Codes section on page 2 of this form.

Anyone who misrepresents, falsifies, or conceals essential information required for payment of state and/or federal funds may be subject to fine, imprisonment, or civil penalty under applicable state and/or federal laws.

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Use applicable HCPCS codes: Not otherwise classified codes will only be authorized in very specific circumstances.

Procedure HCPCS Code(S)	Description & Price(S)