Durable Medical Equipment Authorization Form

Fax completed form to: 608-252-0830

PATIENT DEMOGRAPHICS		
Patient Name:		Date of Birth:
Member ID:		Phone Number:
Street Address:		
City:	State:	Zip Code:

REFERRING PROVIDER INFORMATION			
Provider Name:			Phone #:
Street Address:			Fax #:
City:	State:		Zip Code:
Provider #:	Tax ID #:	NPI:	Specialty:

REFERRED TO PHYSICIAN/FACILITY/PROVIDER INFORMATION			
Referred To:			Phone #
Street Address:			Fax #
City:	State:		Zip Code:
Provider #:	Tax ID #:	NPI:	Specialty:

REQUESTED DATE OF SERVICE	DIAGNOSIS/ICD CODE(S)	

Equipment Information				
Type of Equipment	**HCPCS**	**Quantity**	**Rental or Purchase**	**Price**
Comments:				

Form Submitted By:		
Name:	Phone:	Fax:

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If you have any questions regarding the services or form, please contact Member Services at the number on the member's ID card. or review the Medical Management page. An approved prior authorization is required before obtaining services from non-plan providers.

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