Reset Form

Durable Medical Equipment/ Supply Prior Authorization Request Form

FYI: Review our provider manual criteria references. Submit documentation to support medical necessity along with this request. Failure to provide required documentation may result in denial of request.

Fax form and relevant clinical documentation to:
Clinical Intake at 715.787.7316

For questions, call:
715.631.7443 or 855.931.5265

PATIENT INFORMATION:			
Name:			
Aspirus ID:		PMI:	
Address:			
City:		State:	Zip Code:
Date of Birth:		Phone:	
Living Arrangements:	◯ House/Apt ◯ Assisted Living	◯ Group Home ◯ Nursing Home/SNF	

ORDERING PRACTITIONER INFORMATION: ☐ CONTRACTED ☐ NON-CONTRACTED		
Practitioner Name:		
Address:		
City:	State:	Zip Code:
Clinic Name:	NPI Number (required)*:	
Phone:	Fax:	

DME PROVIDER INFORMATION: ☐ CONTRACTED ☐ NON-CONTRACTED		
DME Point of Contact:		
Phone:	Fax:	
Point of Contact Email:		
Provider Name:	NPI Number (required)*:	
Address:		
City:	State:	Zip Code:

REASON FOR REQUEST: (SELECT ONE)

- ☐ Aspirus Prior Authorization Requirement
- ☐ Out of Network Provider Request
- ☐ Pre-Determination Request (Medicare Only)
- ☐ Experimental/Investigational
- ☐ Benefit Exception

PURCHASE OR RENTAL:	
☐ **Purchase**	☐ **Rental**
Anticipated Date of Purchase:	Date of Delivery:

REPLACEMENT: ☐ YES ☐ NO
Date of Original Purchase/Delivery:
Original Payer:
Cost of Replacement:
Reason for Replacement:

REPAIR: ☐ YES ☐ NO
Make/ Manufacturer:
Original Payer:
Cost of Repair:
Reason for Repair:

CPT/HCPC:

CPT/HCPC Code(s)	Description of Request	# of Units Requested	Start Date	End Date

ICD-10 Diagnosis Codes

PLEASE SELECT STANDARD OR EXPEDITED REQUEST BELOW

STANDARD REQUEST

- Medicare decision within 10 business days.

EXPEDITED REQUEST

- Only request an urgent/emergent review if waiting for the standard review timeframe would potentially jeopardize the member's health, life, or ability to regain function.
- Medicare decision within 72 hours.
- Billing and retrospective authorizations are not expedited.

1. Proposed date of service: _____
   - Billing and retrospective authorizations are not expedited.
2. Clinical reason for urgency (**unrelated to scheduling issues**):
3. Provide a contact name and number available for this request:
   - Due to the expedited processing time, please ensure that the designated contact is readily accessible should further information be required.
4. Clinical notes supporting any of the above have been included in the submission form. (Incomplete submission can delay decision time)

Physician/Practitioner Signature _____ Date _____

NOTE: Description/Additional Information: (Attach manufacturer retail price listing)