ASPIRUS HEALTH PLAN

DME/Supply Prior Authorization Request Form

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. If you are seeking a Medicare Pre-Determination, please use the Medicare Pre-Determination form for your request.

Fax form and any relevant clinical documentation to:
Clinical Intake at **715-787-7316**

For questions, **call** Customer Services at:
715-631-7443 or **855-931-5265**

PATIENT INFORMATION

Member Name _____ Member ID _____

Member Address _____ PMI _____

Member City, State, Zip _____ Date of Birth _____

Member Phone _____

Living Arrangements ☐ House/Apt. ☐ Assisted Living ☐ Group Home ☐ Nursing Home/SNF

ORDERING PROVIDER INFORMATON

Ordering Provider Name _____ ID/NPI Number _____

Ordering Provider Address _____

Ordering Provider City,State,Zip _____

Ordering Provider Phone _____ Fax _____

DME PROVIDER INFORMATION

DME Provider Name _____ ID/NPI Number _____

DME Provider Address _____

DME Provider City, State, Zip _____

DME Point of Contact Person _____

DME Point of Contact Phone _____ Fax _____

DME Point of Contact Email _____

STANDARD / EXPEDITED TIMEFRAME

☐ **Standard Request**

Standard review timeframe for an authorization decision is within **14 calendar days or 10 business days** from the date the request was received, as expeditiously as the member's health condition requires.

☐ **Expedited Request**

Expedited review timeframe for urgent/emergent requests within **72 hours**, as expeditiously as the member's health condition requires. Only request an expedited review if waiting the standard review timeframe would potentially jeopardize the member's health, life or ability to regain function.

ASPIRUS HEALTH PLAN

DME/Supply Prior Authorization Request Form

REASON FOR REQUEST

Reason for request (select one):

- ☐ Aspirus Health Plan prior authorization requirement
- ☐ Out of network provider request (include referring provider information)
- ☐ Experimental/Investigational

REPAIR / RENTAL / PURCHASE

☐ Purchase: Anticipated date of purchase: _____ ☐ Rental: Date of delivery: _____

Is this a replacement: ☐ Yes ☐ No

Date of original purchase or delivery: _____

Original payer: _____

Reason for replacement: _____

Is it a repair? ☐ Yes ☐ No

Make/Manufacturer: _____

Original Payer: _____

Cost of repair: _____ Cost of replacement: _____

ICD -10

ICD-10 Diagnosis Code(s): _____

DME / SUPPLY HCPC / CPT CODE INFORMATION

HCPC/CPT Codes/Units	HCPC/CPT	Qty/Month	Total Qty	Start Date mm/dd/yy	End Date mm/dd/yy

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