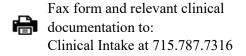


Durable Medical Equipment/ Supply Prior Authorization Request Form

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.



For questions, call: 715.631.7443 or 855.931.5265

PATIENT INFORMATION:				
Name:				
Aspirus ID:	PMI:			
Address:				
City:	State:	Z	Cip Code:	
Date of Birth:	Phone:			
Living Arrangements:		☐ Group Home		
☐ Assisted	Living	☐ Nursing Ho	ome/SNF	
			NON CONTRACTOR	
ORDERING PRACTITIONER INFORMATIO	ON: CON	TRACTED	NON-CONTRACTED	
Practitioner Name:				
Address:	G		r. a. 1	
City:	State:		Zip Code:	
Clinic Name:	NPI Number	(required)*:		
Phone:	Fax:			
DATE DROLLINED DIEGDAL TION		VED A CEED	NON COMED (CEED	
DME PROVIDER INFORMATION:	CON	TRACTED	NON-CONTRACTED	
DME Point of Contact:				
Phone:	Fax:			
Point of Contact Email:	NIDINI 1	/ • 1) di		
Provider Name:	NPI Number	(required)*:		
Address:				
City:	State:	2	Zip Code:	
DELCOVED DECYSOR (ON DOROVE)				
REASON FOR REQUEST: (SELECT ONE)		1/2		
Aspirus Prior Authorization Requirement		ental/Investigationa	Ա	
Out of Network Provider Request	Benefit I	Exception		
Pre-Determination Request (Medicare Only)				
DUD CHA CE OR DENIETA				
PURCHASE OR RENTAL:				
II I Dyynahaga				
Purchase Anticipated Date of Purchase:	Rental Date of Deli			

Date of Original Purchase/Delivery: Original Payer: Cost of Replacement: Reason for Replacement: REPAIR: Make/ Manufacturer: Original Payer: Cost of Repair: Reason for Repair: Reason for Repair: CPT/HCPC: CPT/HCPC Code(s) Description of Request # of Units Requested Start Date End Date	REPLACEMENT:	YES	NO				
Original Payer: Cost of Replacement: Reason for Replacement: REPAIR: WYES NO Make/ Manufacturer: Original Payer: Cost of Repair: Reason for Repair: Reason for Repair: CPT/HCPC: CPT/HCPC Code(s) Description of Request # of Units Requested Start Date End Date							
Cost of Replacement: Reason for Replacement: REPAIR: 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	·						
REPAIR: 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							
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	Reason for Replacemen	nt:					
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							
Original Payer: Cost of Repair: Reason for Repair: CPT/HCPC: CPT/HCPC Code(s) Description of Request # of Units Requested Start Date End Date	REPAIR:	YES	NO				
CPT/HCPC: CPT/HCPC Code(s) Description of Request # of Units Requested Start Date End Date	Make/ Manufacturer:						
Reason for Repair: CPT/HCPC: CPT/HCPC Code(s) Description of Request # of Units Requested Start Date End Date	Original Payer:						
CPT/HCPC: CPT/HCPC Code(s) Description of Request # of Units Requested Start Date End Date							
CPT/HCPC Code(s) Description of Request # of Units Requested Start Date End Date	Reason for Repair:						
CPT/HCPC Code(s) Description of Request # of Units Requested Start Date End Date	PDT/HCDC.						
		Description of Request	# of Units Requested	Start Date	Fnd Date		
ICD-10 Diagnosis Codes	er inner e code(s)	Description of Request	n of Omis requested	Start Date	Liid Date		
ICD-10 Diagnosis Codes							
ICD-10 Diagnosis Codes							
ICD-10 Diagnosis Codes							
ICD-10 Diagnosis Codes							
ICD-10 Diagnosis Codes							
ICD-10 Diagnosis Codes							
	CD-10 Diagnosis C	odes					
PLEASE SELECT STANDARD OR EXPEDITED REQUEST BELOW	LEASE SELECT S	STANDARD OR EX	PEDITED REQUES	T 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 shoul 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)