

Fax form and relevant clinical

Durable Medical Equipment/ Supply Prior Authorization Request Form

For questions, call:

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.

documentation to: 612-884-2499 or 1-866-610	612-676-3300 or 1-888-531-1493			
E-Mail: HCM_Fax@ucare.o	UCare's Secure E-mail Site			
PATIENT INFORMATION:				
Name:				
ID:		PMI:		
Address:				
City:		State:	2	Zip Code:
Date of Birth:		Phone:		
Living Arrangements:	House/Apt. Assisted Livin	ıg [Group Home Nursing Home	/SNF
ORDERING PRACTITIONER INFO	ORMATION:	CON	TRACTED	NON-CONTRACTED
Practitioner Name:			ID/NPI Numbe	r:
Address:				g: 0 1
City:		State:		Zip Code:
Clinic Name:		I_	ID/ NPI Numbe	er:
Phone:		Fax:		
DME DDOVIDED INCODMATION		CON	TDACTED	NON COMED CEED
DME PROVIDER INFORMATION: DME Point of Contact:		CON	TRACTED	NON-CONTRACTED
Phone:		Fax:		
Point of Contact Email:		ı ax.		
Provider Name:		ID/NPI Numbe		
Address:			ID/IVI I IVUIIIOC	1.
City:		State:		Zip Code:
City.		State.		zip code.
REASON FOR REQUEST: (SELEC	T ONE)			
UCare Prior Authorization Requiremen	Experime	Experimental/Investigational		
Out of Network Provider Request	Benefit Exception			
Pre-Determination Request (Medicare Control of the Pre-Determination Representation Representati	Only)		_	
PURCHASE OR RENTAL:				
☐ Purchase		Rental		
Anticipated Date of Purchase:		Date of Delivery:		

REPLACEMENT:	YES NO					
Date of Original Purchase/De						
Original Payer:	Jivery.					
Cost of Replacement:						
Reason for Replacement:						
reason for replacement.						
REPAIR:	YES NO					
Make/ Manufacturer:						
Original Payer:						
Cost of Repair:						
Reason for Repair:						
HCDCC/CDT CODE/C						
HCPCS/ CPT CODE(S):		1				
D : :: 6D						
Description of Request:						
ICD-10 DIAGNOSIS CO	DF(C).					
ICD-10 DIAGNOSIS CO	DE(S):					
Diagnosis description (include	le all) relevant to this request					
Diagnosis description (merae	ie uii) reie vant to tins request	•				
SERVICE/ ITEM REQU	ESTED:					
Number of Units/ Visits Requ						
Frequency: (if applicable)						
Start Date Requested: (require	red)					
End Date Requested:						
STANDARD REQU	EST	EXPEDITED REQUES	ST			
		Only request an urgent/ eme	ergent review if waiting			
Medicare and Medicaid o	lecision within	the standard review timeframe would potentially				
10 business days. ➤ IFP decision within 5 bus	siness dave	jeopardize the member's health, life, or ability to				
7 II I decision within 5 but	siness days.	regain function.				
		Medicare and Medicaid dec				
		> IFP decision within 48 hour	s including 1 business			
		day.	41			
		➤ Billing and retrospective au	thorizations are not			
Will waiting the standard review time seriously jeopardize the member's health, life or ability to regain maximum						
function?						
Yes No						
Clinical reason for urgency (unrelated to scheduling issues):						
Physician Signature:						
NOTE: Description/Additional Information: (Attach manufacturer retail price listing)						