DME INITIAL PRECERTIFICATION FORM

PHONE: 866-248-1972
LOCAL: 570-271-7127
FAX: 570-271-7171

*DME VENDOR:  
*GHP PROVIDER #:  
*LOCATION:  
*PHONE:  
*FORM COMPLETED BY:  
*FAX:  
*MEMBER INFORMATION:  (Last Name, First Name, MI)  
*HEALTH PLAN ID:  
*BIRTHDATE:  

ADDRESS: 

*CURRENT PHONE:  
CAREGIVER/ALTERNATE CONTACT:  

PHONE:  

OTHER INSURANCE INFORMATION: (Workman's Compensation, Auto Insurance, Hospice, other payor, etc, - if applicable)  
COMPANY:  
POLICY NUMBER:  

☐ CONSIGNMENT  
☐ CHANGE OF CARRIER

DIAGNOSIS INFORMATION:  

*DIAGNOSIS CODE:  
DESCRIPTION:  

DIAGNOSIS CODE:  
DESCRIPTION:  

REQUESTED INFORMATION:  

ORDERING PHYSICIAN: (Last Name, First Name)  
*PHONE:  
*FAX:  

PRIMARY CARE PHYSICIAN: (If different than ordering physician) (Last Name, First Name)  

REQUESTED EQUIPMENT: (use extra codes sheet as necessary)  

*ANTICIPATED DELIVERY DATE:  

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<thead>
<tr>
<th>VENDOR REQUEST</th>
<th>FOR INTERNAL USE ONLY</th>
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<tbody>
<tr>
<td>*HCPCS/ MODIFIER</td>
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Required Information. Incomplete forms will be returned unprocessed.

Precertification authorization verifies medical necessity criteria have been met and is not a guarantee of payment.