DME INITIAL PRECERTIFICATION FORM

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

*DME VENDOR: *NPI or GHP PROVIDER #:	*LOCATION: *BRANCH:	*FORM COMPLETED BY:	*PHONE: *EXTENSION: *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)

VENDOR REQUEST

*HCPCS/ MODIFIER	*DESCRIPTION	*QTY

***Required Information. Incomplete forms will be returned unprocessed.**
Precertification authorization verifies medical necessity criteria have been met and is not a guarantee of payment.