

DME EQUIPMENT/SUPPLY PRIOR AUTHORIZATION FORM

Submit this completed form by fax to **1-833-610-2399** or on our provider portal:

https://secure.healthx.com/NHCAdvantage.Provider
Call 1-844-854-6886 (TTY 711) to speak with a representative.

Members must be referred to in-network facilities and providers unless it is an emergency, other exclusions may apply. Authorized services are not a guarantee of payment. Payment is only authorized for medical services noted below and is subject to the limitations and exclusions as outlined in the Member Handbook/ Certification of Coverage. All requests are reviewed for medical necessity. Incomplete submissions may result in processing delays. Information must be legible.

☐ Routine/Standard ☐ Serious jeopa	ardy to	the member's life or l	health or ability to regain	n maximum functio	
	MEM	BER INFORMATION			
Member Name:		Member ID:			
Date of Birth:		Member Residence:			
RF	OUEST	ING PROVIDER/FACIL	ITY		
Requestor's Name (Print):		Phone Number:	Fax Number:	Date of Request:	
		Referring Provider: □NP/PA □PCP □Therapy Rep □Other			
SI		NG PROVIDER/FACILIT			
Servicing Provider Name:					
NPI/ TIN Number:		Phone Number:	Fax number:	Fax number:	
Address:			1		
City:		State:	Zip:	Zip:	
	SERVI	CE TYPE REQUESTED			
□Purchase □Rental S	Start Da		End Date:		
CPT/HCPCS code(s):		# of units requeste	ed:		
Compat Drivery Discourse and ICD 10.0	- (-)				
Current Primary Diagnoses and ICD-10 Code	e(s):				
☐ Replacement		☐ Repair			
Date of Original purchase/Delivery:	Manufacturer:	Manufacturer:			



Original Payer:				
Reason for replacement/repair:				
CLINICAL INFORMATION				
 Please submit written documentation from the medical record to support the procedure, including 				
photos when applicable. Missing this information may delay the decision on your request or may result in				
Lack of Information denial.				
 Documents to attach (where applicable): History and Physical, Therapy Progress Notes, Face-to-face 				
encounter, etc.				
OUT-OF NETWORK SERVICES ONLY				
 Has the service been scheduled already? □Yes □No 				
 Is this a specialized service that no other In-network provider can render? ☐Yes ☐No 				
$ullet$ Does the member have an established relationship with the provider that should not be interrupted? \Box				
Yes □No				
If "Yes", explain (include last visit date):				