PacifiCare®

Durable Medical Equipment Authorization Fax Request Form

Please note: Supporting medical documentation must be submitted with all prior-authorization requests. Incomplete forms and requests submitted without medical documentation cannot be processed and will be returned.

Fax to: Denver Metro Area 303/714-3991 or Outside Denver Metro 888/714-3991

Patient Name: _____ DOB: _____

ID #: _____

Requesting DME Provider: _____ Phone: (_____)_____

Requestor/contact Name:_____ Fax: (_____)_____

Ordering Physician: _____ Phone: (_____)_____

Equipment Requested:_____

HCPCS Code(s): _____

☐ Purchase Purchase Price: $_____ ☐ Rental Monthly Rental Rate: $_____

Patient Diagnosis (description): _____

Dates of Service: from: _____ to _____

Comments:_____

_____

For PacifiCare Use Only:

Reviewer's Initials: _____

☐ **Approved**	☐ **Pending Further Review**	☐ **Not Approved**
Auth #: _____ ***Auth Date(s): From:***_____ **To:** _____	**Comments:**	**Comments:**