Durable Medical Equipment (DME)

Fax completed form to : 608-252-0830

PATIENT DEMOGRAPHICS		
Patient Name:		Date of Birth:
Member ID:		Phone Number:
Street Address:		
City:	State:	Zip Code:

REFERRING PROVIDER INFORMATION			
Provider Name:			Phone #:
Street Address:			Fax #:
City:	State:		Zip Code:
Provider #:		Specialty:	

REFERRED TO PHYSICIAN/FACILITY/PROVIDER INFORMATION		
Referred To:		Phone #
Street Address:		Fax #
City:	State:	Zip Code:
Specialty:		

REQUEST INFORMATION		
Date (s) of Service:	Diagnosis Code(s):	ICD Code(s):
CPT Codes and Description:		
# of Visits	3rd party liability:	☐ W/C ☐ MVA ☐ Other

Equipment Information				
Type of Equipment	**HCPCS**	**Quantity**	**Rental or Purchase**	**Price**
Comments:				

Form Submitted By:		
Name:	Phone:	Fax:

Underwritten by Dean Health Plan, Inc
If you have any questions regarding the services or for, please contact Customer Service at 877-230-7555 or review Prevea360 Health Plan's Medical Management site.
Requests to non-plan providers must be approved prior to obtaining services.
Updated 04/2014