DME PRIOR AUTHORIZATION FORM

Alabama/Florida/South Mississippi

Cigna HealthSpring®

PROVIDER INFORMATION	**MEMBER INFORMATION**
Provider Name:	Name:
Contact:	Member ID#:
Phone #:	DOB:
Fax #:	Previous Auth #:
DOS: From	Ordering MD:
Phone #:	Fax #:
Diagnosis:	ICD-9 Code(s):

Request Type

→

REMEMBER

MD ORDER REQURED TO PROCESS

Standard Request ☐ **Expedited Request** ☐

Please read and sign below if this is an expedited request. Expedited Requests may take up to (72) hours.

Please Read if Expedited Request: By signing below, I certify that applying the standard 72-hour review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

SIGNATURE: ____

Oxygen Therapy

O2 Saturation Level

(Required in Initial Setup)

Equipment/Enteral Feeding (Must submit CMN within (30) days)

Equipment:____________________	Qty.:________	HCPCS Code:____________	Cost:_________
Equipment:____________________	Qty.:________	HCPCS Code:____________	Cost:_________
Equipment:____________________	Qty.:________	HCPCS Code:____________	Cost:_________
Equipment:____________________	Qty.:________	HCPCS Code:____________	Cost:_________
Equipment:____________________	Qty.:________	HCPCS Code:____________	Cost:_________
Equipment:____________________	Qty.:________	HCPCS Code:____________	Cost:_________
Equipment:____________________	Qty.:________	HCPCS Code:____________	Cost:_________
Equipment:____________________	Qty.:________	HCPCS Code:____________	Cost:_________
Equipment:____________________	Qty.:________	HCPCS Code:____________	Cost:_________
Equipment:____________________	Qty.:________	HCPCS Code:____________	Cost:_________

Formula:	HCPCS Code(s):	# of cans:	Cost:

Item(s) requested:	HCPCS Code(s):	Cost:

Types of feeding:

○ Bolus fee ○ Gravity feed ○ Pump

Amount of nutrition formula is providing ____%/ml per day

# of calories ________________

PLEASE FAX THIS FORM ALONG WITH REQUIRED INFORMATION TO:
(205) 444-4284

IF YOU HAVE ANY QUESTIONS, PLEASE CALL:
(205) 423-1222 OR
(800) 962-3018, option 4

Authorization is for medical necessity only and not a guarantee of payment. Eligibility is determined at the time the claim is received and benefits are subject to the limitations and exclusions of the member's plan. Additional information may be required using DMERC criteria.