**Confidential**

# WVMI Medicaid DME / Medical Supplies Authorization Request Form

**Fax:** 304-346-8185 **or** 1-877-762-4338 **Phone:** 304-414-2551 or (Toll Free) 1-800-296-9849

Request Date: _____ Member's Medicaid ID #:_____ Date of Birth: _____
(If Medicaid not primary, denial for requested items must be attached)

A. **Member** Name: _____ Phone #:_____
Member Address: _____

B. **Prescribing Practitioner N**ame: _____
Mailing Address: _____

**Contact** Name: _____ Phone# (_____) _____ Ext: _____
Fax # (_____) _____ E-Mail Address:_____

C. Name of **DME Vendor** Selected by Member: _____
Physical Address: _____
Provider #: _____ Phone #:_____Fax #:_____

D.

| ICD-9 Codes | Clinical Diagnosis | Date of Onset |
|---|---|---|
| | | |
| | | |
| | | |

E.

| HCPCS Code | Item Description | Length of Need (# of Months) | Quantity & Frequency of Use |
|---|---|---|---|
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F. **Clinical Indication(s) for Item(s) requested:** _____
_____
_____
_____

G. **PRACTITIONER CERTIFICATION**

I certify that I have examined the member within the past 6 months and the equipment and/or supplies requested are part of the plan of care. They are reasonable, medically necessary, and cost effective, and are not a convenience item for the member or any individual involved with the member's care. I certify that the member or his representative have been offered a choice of vendors.

_____ _____ _____
Prescribing Practitioner's Signature ***(required)*** Medicaid ID# Date

***** REMINDER: Preauthorization for medical necessity does not guarantee payment***

**For WVMI Use Only:**

**Approved: ___ Authorization Number: _____ Date: _____**

**Denied: ____ Detailed letter to follow**

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