Advanced Health
289 LaClair St, Coos Bay, OR 97420
Voice: 541-269-7400 • 800-264-0014
Fax: 541-269-7147
TTY: 711 or 800-735-1232

Instructions to Complete Service Authorization Request Form for *Durable Medical Equipment (DME) or Oral Enteral Supplements*

- Provider is responsible for submitting all information on the form.
- **Required Documentation:**

  DME:

  - DME requiring Certificates of Medical Necessity (CMN's) can be submitted with the dispensing RX. The request will be pended waiting the receipt of CMN or other information as requested.

  Oral Enteral Supplements:

  - Criteria letter must be submitted with request as well as the prescription. Units submitted must be in calories, not cans per day.
- Fax completed form and documentation to Advanced Health's Medical Management Department at (541) 269-7147.
- If you have questions regarding this form or other related questions, please contact Advanced Health's Medical Management Department at (541) 269-7400.

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Durable Medical Equipment Authorization Request

☐ **STANDARD REQUEST** ☐ **EXPEDITED REQUEST - 72 hours (member's health is at immediate risk i.e. loss of life, limb, or eyesight imminent)** ***(Fill out Justification below:)***

****Justification within submitted documentation is required for Expedited processing. If your PA request does not meet Expedited criteria, it will receive Standard processing. Expedited requests are appropriate if Standard Time Frame could seriously jeopardize a Member's life or health, or their ability to attain or maintain or regain maximum function.**
JUSTIFICATION:

• Fax Completed Form and chart notes to 541-269-7147 *PLEASE NOTE: INCOMPLETE FORMS WILL NOT BE PROCESSED*

Member Name: _____ Medicaid ID #: _____ DOB: ____/____/

Requesting Provider: _____ PCP ☐ Specialist ☐ Other ☐

Requesting Provider NPI#: _____

Provider's Phone Number: _____ Provider's Fax Number: _____

Prescribing Provider: _____ PCP: _____

Prescribing Provider NPI#:_____ Requested Dates: ____/____/____ to ____/____/____

PRIMARY ICD-10 Code: _____ Other Related ICD-10 Codes: _____, _____

Is this a retro-active request: ☐ Yes ☐ No If "Yes", enter the date of service: ____/____/____

****You must attach chart notes/operative report from that date.**

Item / Service Requested	HCPCS Code / Modifiers	Quantity Requested

*****Submit additional codes/items on separate sheet.**

Required Documents Attached?: ☐ **Yes** ☐ **No** **(EX: MD Notes Supporting Condition)**

PLEASE NOTE: INCOMPLETE FORMS WITHOUT REQUIRED DOCUMENTS WILL DELAY THE AUTHORIZATION PROCESS

List Documents:

Other Information:

Person Completing Form: _____

Phone:_____ Fax:_____ Date ____/____/____

Disclaimer: Prior Authorization does not guarantee payment. Depends on patient eligibility on date of service, contract terms, and compliance with rules, regulations and policies of DMAP, Medicare and Advanced Health as applicable.

(Rev 1/23)