



**Durable Medical Equipment Authorization Request
(Please Print)**

MEMBER INFORMATION			
Member Number:		Group Name and Number:	
Member Name:			Date of Birth: / /
Street Address:			
City:	State:	Zip Code:	
Date of Service: / /	Diagnosis:	ICD-9 Code:	
DURABLE MEDICAL EQUIPMENT PROVIDER INFORMATION			
DME Provider:		Provider #	Phone #
Street Address:			Fax #
City:	State:	Zip Code:	Request submitted by:
REFERRING PHYSICIAN INFORMATION			
Referring Physician:			Phone #
Street Address:			Fax #
City:	State:	Zip Code:	
EQUIPMENT INFORMATION			
Type of Equipment	HCPCS	Quantity	Rental or Purchase (R or P)
COMMENTS			