

DME Authorization Request Form

DME Fax Information	
Submit request via our Provider Portal If the portal is down, requests may be faxed to: Medicaid/CHIP/Individual and Family Plans: 215-849-4749 Medicare Advantage: 267-515-6636	DME Provider Name: DME PROMISE ID #:
DME Contact	DME Phone:
Date:	DME Fax:

Provider - Please Complete Area Below		
Member Name:	Member ID #:	Member DOB:
Dates of Service Requested:	Duration of Service:	
ICD 10/Diagnosis:	Description of Medical Condition/Diagnosis:	
Ordering Physician Name:	Phone:	
PROMISE ID#:	Fax:	
Attachments (Supporting the Requested Clinical Service): Physician-Signed Prescription Letter of Medical Necessity (LMN) DME Manufacturer's Invoice (if applicable)		Authorization will be denied without documentation of medical necessity <i>and</i> PROMISE ID
Additional Details (e.g., volume, frequency, route, total number units. Note: Use NU or RR modifier as required.)		

Please complete the HCPCS Codes section on page 2 of this form.

Anyone who misrepresents, falsifies, or conceals essential information required for payment of state and/or federal funds may be subject to fine, imprisonment, or civil penalty under applicable state and/or federal laws.

