# PRE-CERTIFICATION FAX FORM FOR DURABLE MEDICAL EQUIPMENT

CONFIDENTIAL FAX TRANSMITTAL
Fax form to: 1.888.329.8471 or 740.695.5297.

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|---|---|
| Name of Person Submitting Form: | |
| Phone Number: | |
| MEMBER (PATIENT) INFORMATION | |
| Name: | Date of Birth: |
| The Health Plan ID#: | PCP Name: |
| DIAGNOSIS - EQUIPMENT INFORMATION | |
| Diagnosis: | Date of Service: |

| Equipment Ordered | HCPCS Code | Modifier | Date(s) |
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|---|---|
| DME Provider: | Phone: |
| Contact Person: | Fax: |

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|---|---|
| THE HEALTH PLAN USE ONLY: | |
| Referral/Authorization Number: | |
| Authorized By: | Phone: |
| Comments: | |

**Documentation of medical necessity is required for all durable medical equipment. Providers should refer to The Health Plan Fee Schedule and DME policies available on The Health Plan website for information regarding items that require precertification. The Health Plan reserves the right to request additional information as necessary to complete reviews.**
**Coverage of durable medical equipment is based on member's benefits, provider contracts, and any/all applicable limitations and exclusions.**