

Patient name: _____ DOB: _____ Member ID: _____

Provider: _____

Provider address: _____

Provider phone: _____ Provider fax: _____ Provider NPI #: _____

Requesting physician: _____

Physician address: _____

Physician phone: _____ Physician fax: _____ Physician NPI #: _____

Equipment start date: _____ New: _____ Used: _____

Rental or purchase? _____

Notification #: _____

In order to review the medical necessity for this service, we need the following information:

- Prescription for the requested durable medical equipment
- Documentation of medical necessity
- Replacement equipment requires documentation of disrepair / out of warranty

Relevant diagnosis and past medical history (related to the equipment): _____

Functional status (specify): _____

Where does the patient reside? ____ Own home ____ SNF ____ Other (specify) _____

How long do you anticipate the patient will require this equipment?

of days _____ # of weeks _____ # of months _____ Indefinite _____

Types of medical equipment with HCPC codes and prices (circle requested information):

Apnea: HCPC _____ Purchase \$ _____ Rental \$ _____ per D/W/M

Cardiac: HCPC _____ Purchase \$ _____ Rental \$ _____ per D/W/M

Oximetry: HCPC _____ Purchase \$ _____ Rental \$ _____ per D/W/M

Uterine: HCPC _____ Purchase \$ _____ Rental \$ _____ per D/W/M

Accessories (if applicable): _____ HCPC _____ \$ _____

_____ HCPC _____ \$ _____

UniCare has preferred providers for DME services. To get the maximum benefit, a preferred provider must be used. UniCare covers the allowed rental charge up to the allowed purchase price for approved durable medical equipment.

Signature: _____ **Date:** _____

Print name: _____ **Phone:** _____

After completing this form and obtaining the necessary clinical information, please fax to 800-848-3623.