

 carelon
DMEPOS Prior Authorization Request Form

FOR FASTER AUTHORIZATION, PLEASE VISIT:
<https://providers.carelionmedicalbenefitsmanagement.com/postacute/>

PLEASE FAX THIS FORM ALONG WITH REQUIRED INFORMATION TO: 833-678-0223

Questions? Call 844-411-9622

Date of Request: _____

Standard Request: ☐

Urgent Request: ☐

Note: Expedited organization determinations (urgent requests), can only be requested by the Member, Member Representative, or a Physician and only if applying the standard timeframe could seriously jeopardize the life or health of the member. (See CMS regulation: 40.8)

Note: To prevent delay in processing your request, fill out this form in its entirety with all applicable information. Include ALL clinical information and other supporting documentation with this form to support each HCPCS requested.

Member Information

First Name: _____

DOB: _____

Member ID: _____

Middle Name: _____

Ht: _____ ft _____ in

Health Plan: _____

Last Name: _____

Wt: _____ lbs

Member Location

Location the DMEPOS will be used

Home ☐ Assisted Living ☐ Group Home ☐ Other(explain) _____

Your Information

Name: _____

Secure Fax: _____

Phone Number: _____ Ext: _____ Email: _____

ICD 10 Diagnosis Code(s) (at least one required)

Primary

DMEPOS Provider

Enter NPI and Tax ID of provider dispensing DMEPOS product.

DMEPOS Provider NPI: _____ DMEPOS Provider Tax ID: _____

DMEPOS Provider Name: _____ Phone: _____ Secure Fax: _____

Physical Address: _____ City, State, Zip: _____

Ordering Provider (Physician/Treating Practitioner)

Ordering Provider (Physician/Treating Practitioner) NPI: _____

First Name: _____ Phone: _____ Street Address: _____

Last Name: _____ Secure Fax: _____ City, State, Zip: _____

