



Plan:

☐ **Virginia Premier**
Fax: 800-827-7192
Phone: 888-251-3063

☐ **Virginia Premier Complete Care**
Fax: 877-739-1364
Phone: 888-251-3063

Durable Medical Equipment (DME) Prior Authorization Form

Fax completed form to Medical-Management

Member Name: Last, First	Member ID #	Date of Birth	Today's Date:

SUPPLYING PROVIDER INFORMATION

Type: ☐ Office ☐ DME Supplier ☐ Orthotics/Prosthetics Supplier ☐ Other

Provider Name: _____ NPI or Tax ID: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

EQUIPMENT/MEDICAL SUPPLY INFORMATION

*****Current signed and dated physician order/CMN required.*****

Please submit supportive clinical documentation to substantiate the need for the proposed equipment/ item or service including but not limited to: H&P, office notes, laboratory and imaging results and skilled therapy reports.

Diagnosis code(s): _____ Description/Condition: _____

HCPSC/CPT Code(s)	Description of Item	# of Units	Rental (R) /Purchase (P)	Begin Date of Service

For Orthotics/Prosthetics: (Check one) ☐ Left ☐ Right ☐ Bilateral

For Wheelchairs and Hospital Beds: Weight _____ Height _____

For Oxygen: O2 Sat _____ Date: _____

For CPAP (convert to purchase): CPAP download (continuous 30-days): Date(s) _____ -- _____

Person Completing this Form: _____

Phone: _____ ext. _____

Fax: _____

Ordering Provider: (Full Name) _____ Provider Signature: _____

NPI or Tax ID: _____ Phone #: _____ Fax #: _____



Member Name: _____ Member ID#: _____

***For additional items for the same PA#, use additional form. Include Member Name and ID#.**

HCPSC/CPT Code(s)	Description of Item	# of Units	Rental (R) /Purchase (P)	Begin Date of Service

Ordering Provider: (Full Name) _____ Provider Signature: _____

NPI or Tax ID: _____