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DME Authorization Request

*Indicates a required field

Requirements: Clinical information and supportive documentation should consist of current physician order, notes and recent diagnostics. **Notification is required for any date of service change.** **Expedited Requests:** If the standard time for making a determination could seriously jeopardize the life and/or health of the member or the member's ability to regain maximum function, please call

Fax completed form to

Requestor Name: _____ Fax*: _____ Phone*: _____

MEMBER INFO (Please Print)			
WellCare ID*:	Medicaid/Medicare ID:		
Last Name*:	First Name, MI*:	Date of Birth*: / /	
ORDERING PROVIDER (Please Print)			
WellCare ID:	NPI/Tax ID*:		
Provider Name*:	Address:		
City, State, ZIP:	Fax*:	Phone:	
DISPENSING PROVIDER* (Please Print)			
WellCare ID:	<input type="checkbox"/> Plan to Assign	NPI/Tax ID*:	
Provider Name*:	Address:		
City, State, ZIP:	Fax*:	Phone:	
REQUESTED EQUIPMENT* (Please Print)			
Please submit separate requests for Prosthetics vs. Orthotics and Purchases vs Rentals			
<input type="checkbox"/> Prosthetic <input type="checkbox"/> Orthotics		<input type="checkbox"/> Purchase <input type="checkbox"/> Rental x ____ Months	
Is item needed for discharge? (circle one) Y/N		Discharge Date: ____/____/____	
Has this item been dispensed*? (circle one) Y/N		Dispense Date: ____/____/____	
ICD-10 Code*:	ICD-10 Code:	ICD-10 Code:	ICD-10 Code:
HCPC Code*:	Description:	Units:	
HCPC Code:	Description:	Units:	
HCPC Code:	Description:	Units:	
HCPC Code:	Description:	Units:	
HCPC Code:	Description:	Units:	

Please include additional clinicals, as well as additional codes (if needed)