



DME Authorization Request Form

**Indicates a required field*

Requirements: Clinical information and supporting documentation should consist of current physician orders, notes, and recent diagnostics. **Notification is required for any date-of-service change.**

Expedited Requests: If the standard time to make a determination could seriously jeopardize the life and/or health of the member or the member's ability to regain maximum function, please call **1-855-538-0454**.

 **Please fax completed form to appropriate number at bottom of form.**

Requestor Name*:	Fax*:	Phone*:
------------------	-------	---------

Member Information (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*:	Fax*:	Phone:
Address:	City:	State: ZIP Code:

Dispensing Provider (please print)

Wellcare ID:	<input type="checkbox"/> Plan to Assign	NPI/Tax ID*:
Provider Name*:	Fax*:	Phone:
Address:	City:	State: ZIP Code:

Place of Service*

Office (11) Home (12) Other (please specify): _____

Diagnosis Codes*

ICD-10:	ICD-10:	ICD-10:	ICD-10:
---------	---------	---------	---------

(continued)

