



## DME REQUEST FORM

(REPLACES THE HHS TITLE XIX DME/MEDICAL SUPPLIES PRESCRIBING PROVIDER ORDER FORM)

MEMBER INFORMATION			
Member Name*:		Referral Date:	
Member DOB*:		Phone:	
Address:			
Medicare Number*:		Medicaid Number*:	
STAR Plus Waiver:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Dual <input type="checkbox"/> Non-Dual	
Member DX:			
RENDERING DME PROVIDER INFORMATION (Requesting Provider)			
Provider Name*:		Phone:	
Provider Address*:			
Provider Fax Number:			
Tax ID*:		NPI*:	
Taxonomy*:		Benefit Code*:	
<p>Items/Services requested: <i>Check off items needed on the right to include *quantity (units) and</i></p> <p><i>Include *HCPCS Code(s) below:</i></p> <p>- _____</p> <p>- _____</p> <p>- _____</p> <p>- _____</p> <p>- _____</p> <p>- _____</p> <p>- _____</p> <p>- _____</p> <p>- _____</p> <p>- _____</p>	<input type="checkbox"/> Incontinence supplies: Total units _____ <input type="checkbox"/> Adult Diapers size: _____ <input type="checkbox"/> Pull-on briefs size: _____ <input type="checkbox"/> Chux, underpads: _____ <input type="checkbox"/> Wipes, barrier cream: _____ <input type="checkbox"/> Walker (standard): _____ <input type="checkbox"/> Walker w/wheels: _____ <input type="checkbox"/> Rollator (walker w/wheels & seat): _____ <input type="checkbox"/> Mobile Stander: _____ <input type="checkbox"/> Hospital bed: _____ <input type="checkbox"/> Air mattress: _____ <input type="checkbox"/> Hoyer Lift: _____ <input type="checkbox"/> Bath Lift: _____ <input type="checkbox"/> Trapeze Bar: _____ <input type="checkbox"/> Transfer board: _____ Other services needed (specify): _____	<input type="checkbox"/> Wheelchair (manual standard): _____ <input type="checkbox"/> Wheelchair cushion: _____ <input type="checkbox"/> Specialty wheelchair (specify): _____ <input type="checkbox"/> Power Wheelchair: _____ <input type="checkbox"/> Scooter: _____ <input type="checkbox"/> Enterals (specify): _____ <input type="checkbox"/> Nutritional Supplements (specify): _____ <input type="checkbox"/> Blood Pressure Monitor: _____ <input type="checkbox"/> Glucometer & Supplies: _____ <input type="checkbox"/> Shower chair: _____ <input type="checkbox"/> Bedside commode: _____ <input type="checkbox"/> Tub Transfer Bench: _____ <input type="checkbox"/> Raised Toilet Seat: _____	
REQUESTING PHYSICIAN OR ALLOWED PRACTITIONER INFORMATION (Attach Signed and Dated Physician Order)			
Name*:		NPI*:	
Phone:		Fax:	
Duration of need for DME/Supplies:	_____ month (s)	Date of Services:	From _____ To _____

*Note: Medicaid is payor of last resort. Please coordinate benefits as appropriate.*

*Note: EPH has removed prior auth requirement for Incontinence Supplies unless exceeding allowable limits by TMPPM 2.2.15, Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook.*

\* Essential/Critical field (information must be entered) or prior authorization will be returned