Durable Medical Equipment Preauthorization Request Form

Please complete each section of this form. NOTE: For your patient to receive the lowest out-of-pocket costs, use in-network providers unless preauthorization is obtained. Decisions are based on eligibility, benefit determination and medical necessity.

****Incomplete forms will not be processed; this form must be filled out completely.**

Member's Name: _____ Member's DOB: _____

Member's ID Number: _____ Group Number: _____

ICD code(s), please list all that apply: _____

CPT & HCPCS code(s), please list all that apply: _____

Supplier: _____ NPI: _____

Supplier Address: _____

Ordering Provider: _____ NPI: _____

Provider Address: _____

Start of Service Date: _____ Days/Units Requesting: _____

Are you requesting In-Network Benefits for an Out-of-Network Provider/Supplier: ☐ YES ☐ NO

Initial/New Request: ☐ Replacement Request: ☐ Continuation of Care Request: ☐

Durable Medical Equipment

☐ Chest Vest	☐ Hyperbaric Oxygen	☐ Infusion/Implantable Pump
☐ Lift Systems	☐ Medical Bed/Mattress	☐ Nerve Stimulation System
☐ Neuromuscular Stimulation Systems	☐ Passive Motion Exercise Device	☐ Pneumatic Compression Device
☐ Speech Generating Devices & Accessories	☐ Transfer Systems	☐ Ultraviolet Therapy
☐ Orthotics/Prosthetics (if billed amount exceeding $15,000)	☐ Wheelchair/Mobility Devices & Accessories	☐ Pain Management Services
☐ Wound Therapy Devices & Supplies	☐ Other _____	

Person completing the form: _____ Today's Date: _____

Office/Facility Name: _____

Phone Number: (_____) _____ Fax Number: (_____) _____

Determination of medical necessity requires the submission of documentation.

☐ Clinical documentation is available in the Avera electronic medical record for review.
Please list date(s) of pertinent records: _____

☐ Clinical documentation is not available in the Avera electronic medical record for review. Pertinent clinical records for the previous 12 months are attached for review.

Final determination will be faxed to the prescriber. Final determination will be mailed to the member.

IMPORTANT NOTICE*:* This determination does not guarantee benefits or payment of services. Payment of services is subject to patient eligibility at the time of treatment, benefit plan limitations and the other terms of the benefit plan. Payment of benefits is only made for services deemed medically necessary and appropriate. The final payment decision will be made upon submission of a claim to Avera Health Plans. If you have questions about your benefits, please contact Avera Health Plans Service Center at 605-322-4545 or toll-free at 1-888-322-2115. This form is not all-inclusive of services requiring preauthorization. Refer to patient's Certificate of Coverage, Master Contract or Summary Plan Document for more information.

Fax this completed form to Avera Health Plans at **1-800-269-8561** or send a secure email to HealthServices@AveraHealthPlans.com.