

## DURABLE MEDICAL EQUIPMENT (DME) PRIOR AUTHORIZATION REQUEST FORM

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<b>From:</b> (Provider) _____ (Sender) _____ <b>Phone:</b> _____ <b>Fax:</b> _____	<b>Address:</b> _____ _____ <b>TIN:</b> _____ <b>Date of Request:</b> _____
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**\*IMPORTANT MESSAGE\***

This message is intended for the use of the individual to which it is addressed. It may contain information that is privileged, confidential, and exempt from disclosure under law. If the reader of this message is not the intended recipient, or employee, or agent responsible for delivering the message to the intended recipient, you are notified that any dissemination, distribution, or copying of this communication is strictly prohibited.

If you have received this communication in error, please notify the sender and destroy or delete this communication immediately. Thank you.

Completed by plan:	Authorization #: _____	Authorized by: _____
Comments:	Date Span: _____	Phone #: _____

1. Patient Name:	2. Patient DOB: _____ / _____ / _____	3. Member Insurance ID #:
4. ICD-10-CM:      ICD-10-CM:      ICD-10-CM:	5. Diagnosis:	8. Name of Referring Physician:
7. Start Date:      /      /      End Date:      /      /		

HCPC CODES:	# of Units:	Price:	Description:
1.			
2.			
3.			
4.			
5.			

**Total Price:** \_\_\_\_\_

**NOTE: \*A benefit reduction of 20 percent applies if preauthorization is not obtained at the time of service\***