THE OHIO STATE UNIVERSITY
HEALTH PLAN

DURABLE MEDICAL EQUIPMENT (DME) PRIOR AUTHORIZATION REQUEST FORM

700 Ackerman Road, Suite 1007
Columbus, OH 43202
Phone: (614) 292-4700 • Fax: (614) 292-2667
Email: UtilizationManagement.OSUHealthPlan@osumc.edu

From: (Provider) _____ **Address**: _____
(Sender) _____ _____
Phone: _____ **TIN**: _____
Fax: _____ **Date of Request**: _____

IMPORTANT MESSAGE

Completed by plan: Authorization #: _____ Authorized by: _____

Date Span: _____ Phone #: _____

Comments:

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*

This Authorization is for medical necessity only. It is not a guarantee of payment. Approval of benefits is subject to premium payments and coverage limitations, including waiting periods where applicable.