PEHP Health & Benefits

PRIOR AUTHORIZATION for MISCELLANEOUS DURABLE MEDICAL EQUIPMENT

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Customer Service at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

Date Requested:	Name (Last, First MI):	DOB:	Age:	PEHP ID #:

Section II: PROVIDER(S) INFORMATION

Ordering **Provider:**		**Ordering Provider Address:**			
Ordering Provider NPI #:	**Ordering Provider TIN #:**	**Contact Person:**	**Phone:** ( )	**Facsimile:** ( )	**Email Address:**
Rendering **Provider:**		**Rendering Provider Address:**			
Rendering Provider NPI #:	**Rendering Provider TIN #:**	**Contact Person:**	**Phone:** ( )	**Facsimile:** ( )	**Email Address:**

Section III: AUTHORIZATION REQUEST

Nature of Request: *Please check.* ☐ Authorization Extension ☐ Pre-Authorization ☐ Retro Authorization ☐ Urgent	**Requested Date(s) of Service:** **From:** **To:**
Primary Diagnosis/ICD-10 Code:	**Secondary Diagnosis/ICD-10 Code:**
Date of Injury and/or Surgery:	**Description of Injury and/or Surgery:**
Are services related to a motor vehicle accident? ☐ Yes ☐ No *Date of Accident:* ________________________	**Are services related to a work-related injury?** ☐Yes ☐ No *Date of Work Injury:* ________________________

A. Durable Medical Equipment (DME) Service Requested: ***Please check all that apply.***

1. ☐ Duplicative Equipment
2. ☐ Initial Purchase
3. ☐ Initial Rental
4. ☐ Non-Routine Maintenance by Skilled Technician
5. ☐ Non-Routine Repair
6. ☐ Rental Extension
7. ☐ Rental while Purchased DME is being Repaired
8. ☐ Routine Maintenance
9. ☐ Upgrade
10. ☐ Replacement ****Please check or specify reason below.***
    a. ☐Change in Medical/Functional Status b. ☐Height Change c. ☐Lost/Stolen d. ☐Unrepairable
    e. ☐Unrepairable/Warranty Expired f. ☐Weight Change g. ☐Other ____________________

B. How long will the device be needed?	**C. Does the patient currently own DME being replaced?** ☐Yes ☐ No	**D. Biometrics:**	**E. Current Level of Mobility:** ***Please check all that apply.***
☐ Lifetime ☐ # of Months _________	Purchase Date: ________________ Warranty Exp Date: ______________	Height: _______________ Weight: ______________	1. ☐Ambulatory 2. ☐ Ambulatory with Assist Device 3. ☐Bed Confined 4. ☐Chair Confined 5. ☐Prosthetic K Level: ☐0 ☐1 ☐2 ☐3 ☐4

Service/DME Requested: ***Please list all requested services regardless of pre-authorization requirement and for unlisted codes, please provide comparable code(s).***

Service/DME Description: ____ CPT/HCPCS: ____________________
Please check all that apply: ☐Bilateral Sides ☐Duplicate ☐Left Side ☐Right Side ☐Purchase ☐Rental ☐Repair ☐Replacement ☐Upgrade

Service/DME Description: ____ CPT/HCPCS: ____________________
Please check all that apply: ☐Bilateral Sides ☐Duplicate ☐Left Side ☐Right Side ☐Purchase ☐Rental ☐Repair ☐Replacement ☐Upgrade

Service/DME Description: ____ CPT/HCPCS: ____________________
Please check all that apply: ☐Bilateral Sides ☐Duplicate ☐Left Side ☐Right Side ☐Purchase ☐Rental ☐Repair ☐Replacement ☐Upgrade

Service/DME Description: ____ CPT/HCPCS: ____________________
Please check all that apply: ☐Bilateral Sides ☐Duplicate ☐Left Side ☐Right Side ☐Purchase ☐Rental ☐Repair ☐Replacement ☐Upgrade

Service/DME Description: ____ CPT/HCPCS: ____________________
Please check all that apply: ☐Bilateral Sides ☐Duplicate ☐Left Side ☐Right Side ☐Purchase ☐Rental ☐Repair ☐Replacement ☐Upgrade

Additional Comments:

By submitting this form, I attest that the information provided is true and accurate to the best of my knowledge.

****Please fax completed form and medical records to 801-366-7449.***