Fax completed form to **888.647.6152** (standard & retrospective) or **616.975.8892** (expedited only) Questions? Call our Provider Helpline at **800.942.4765**.



## DME / P&O prior authorization form

Check if requesting on behalf of a Cigna-participating provider

Check if your request is a Medicare Pre-Service Organization Determination (PSOD)

Member last name   Member first name   Priority Health ID#   Date of birth	Date of request:									
Priority Health ID#  Requested by  Ordering physician Ordering physician NPI  Phone Fax Diagnosis code(s)  Address Diagnosis (description)  Requested date span From: To:  Request type – length of rental must be on fix  Request priority Standard Expedited*  Standard Expedited*  Purchase Rental  Standard Expedited*  Provider tax ID Provider name Phone Fax  Address Contact name  Mandatory documentation for prior authorization  • Complete description and medical necessity for NOC codes • Copy of physician's order with supporting documentation to show medical necessity • Repairs as follows:  • Medicaid greater than \$500  • HMO, POS, Medicare greater than \$1,000  • ASO greater than \$1,000 – check to see if specific group covers  • Prosthetics: K level	Member information			Member	firet name					
Requested by  Ordering physician   Ordering physician NPI    Phone   Fax    Address   Diagnosis code(s)    Pequested date span   From: To:  Request dype - length of rental must be on Rx    Request priority   Standard   Expedited*  Standard   Expedited*  Standard   Expedited*  Purchase   Rental    Request priority   Standard   Expedited*  Standard   Expedited*  Provider information of the member or the member's ability to regain maximum function.  Directed to (DME provider information)  Provider name   Provider tax ID    Address   Phone   Fax    Contact name  Mandatory documentation for prior authorization  • Complete description and medical necessity for NOC codes   • Copy of physician's order with supporting documentation to show medical necessity   • Repairs as follows:  • Medicaid greater than \$500   • Modicaid greater than \$1,000 - check to see if specific group covers   • Prosthetics: K level   • Date similar item last received:   • Date similar item last received:   • Date similar item last received:   • Mobility devices: Provide answers to medical necessity according to InterQual®										
Ordering physician	Priority Health 10#			Date of	OIRTH					
Address    Diagnosis code(s)	Requested by									
Address   Diagnosis code(s)	Ordering physician			Ordering	g physician NPI					
Address   Diagnosis (description)    Requested date span   From: To:  Request type = length of rental must be on Rx   Purchase   Rental    Request priority   Standard   Expedited*    *By checking this box, I attest that the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.  Directed to (DME provider information)    Provider name   Provider tax ID    Address   Phone   Fax    Contact name    Mandatory documentation for prior authorization    • Complete description and medical necessity for NOC codes    • Copy of physician's order with supporting documentation to show medical necessity    • Repairs as follows:    • Medicaid greater than \$500    • Medicaid greater than \$1,000    • ASO greater than \$1,000   check to see if specific group covers    • Prosthetics: K level      • Date similar item last received:    • Mobility devices: Provide answers to medical necessity according to InterQual®    Quantity   Procedure   Make/Model   Description   Retail   R/P	Phone			Fax			-			
Requested date span	A dalaman			Diagnosis code(s)						
Request type – length of rental must be on Rx  Request priority  Standard  Expedited*  *By checking this box, I attest that the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.  Provider name  Provider tax ID  Phone  Phone  Contact name  Mandatory documentation for prior authorization  Complete description and medical necessity for NOC codes Copy of physician's order with supporting documentation to show medical necessity Repairs as follows:  Medicaid greater than \$500  Medicaid greater than \$1,000  Medicaid greater than \$1,000 – check to see if specific group covers  Prosthetics: K level  Date similar item last received:  Mobility devices: Provide answers to medical necessity according to InterQual®	Address			Diagnosis (description)						
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Quantity         Procedure         Make/Model         Description         Retail         R/P	<ul> <li>Complete descrip</li> <li>Copy of physician</li> <li>Repairs as follow         <ul> <li>Medicai</li> <li>HMO, P</li> <li>ASO gree</li> </ul> </li> <li>Prosthetics: K lev</li> <li>Date similar item</li> </ul>	otion and medical r n's order with supp vs: d greater than \$50 POS, Medicare grea eater than \$1,000 - vel last received:	ecessity for NO0 orting documenta  orting the state of th	ation to show	p covers	ity				
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		re Make/	Model L	Description			Retail		R/P	

To facilitate prompt, accurate processing, the information above must be complete and all supporting clinical documentation related to this request MUST be submitted with this form.