



DME/Medical Supply Request Form

Fax: (602) 778-3331

Phone: (602) 778-3330
1-866-406-0955

Date of Request: _____

Routine

Urgent

Member Name: _____ ID#: _____ DOB: _____

Dates of Service: From: _____ To: _____ Diagnosis (ICD-9 Code): _____

Ordering Physician: _____ Telephone #: _____ Fax #: _____

HCPC Code	Description of Ordered Product	Medicare Covered? Y or N	Excess Quantity Ordered	Ordered Quantity	Medicare Covered Quantity	ALTCS Covered Benefit? Y or N	SCAN Contracted Price

Comments (if possible please fax in supporting documentation with request): _____

Contact Name: _____ **Ext:** _____ **Date:** _____

HEALTH PLAN USE ONLY

Approved
Authorization Number: _____ **Valid From:** _____ **to** _____ **Expiration Date**

Denied **Denial Reason:** _____

Medical Director Signature

PA Nurse/Tech Signature

Date