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DME PRIOR AUTHORIZATION REQUEST FORM

*****Form must filled out completely and clinical information attached*****

Purchase | **Initial Rental** | **Additional Rental to existing auth #__**

☐ Select this box if the member is new to HTA and these services were previously authorized by another health plan.

Submitted by: (select one) ❑ Provider Office ❑ DMESupplier	Today's Date: / /
Person to contact for this Submission:	Phone:

Patient's Name:	**DOB:**	**Member ID**:

Requesting Provider Information:	**DME Supplier Information:**
Name:	Name:
NPI:	NPI:
Tax ID:	Tax ID:
Address:	Address:
Fax:	Fax:
Phone:	Phone:

Check one and complete the Date Range, below.

•	Proposed Dates of Service	Services that have not yet been provided. Purchase DME: Max 90 days. Rental DME: Max 13 months.	
•	Retro Dates of Service	Services that have already been provided/started. Purchase DME: Max 90 days. Rental DME: Max 13 months. **INITIAL** Retro requests must be submitted within 7 days from the start date. **ADDITIONAL** rental requests must be submitted prior to start of new rental period.	
	Date Range	From:	To:

ICD-10 Code	Diagnosis Description	ICD-10 Code	Diagnosis Description
1.		3.	
2.		4.	

CPT/HCPCS Code	Rental or Purchase	90 Day Quantity or # of Months of Rental

This request will be processed per the standard organization determination timeframes. If this request needs to be treated as "expedited", please note clinical justification why applying the standard timeframe for a determination could seriously **jeopardize the member's life, health or ability to regain maximum function:**

Authorization does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitation, provisions and exclusions. Please refer to www.htanc.com for specific codes requiring a prior authorization.