DME PRE-AUTHORIZATION/LETTER OF MEDICAL NECESSITY

PATIENT'S NAME: _____ DOB _____
INSURANCE CARRIER _____ ID NUMBER _____

ITEM REQUESTED _____
_____

DIAGNOSIS CODE: _____

CLINICAL JUSTIFICATION: _____
_____
_____

FREQUENCY OF USE: _____
DURATION OF USE: _____

ITEM IS BEING:

RENTED _____ FEE: _____
PURCHASED _____ FEE: _____
RENT TO PURCHASE _____ FEE: _____

ANCILLARY SUPPLIES: _____
_____
_____

PHYSICIAN NAME _____
PHYSICIAN ID NUMBER _____
PHYSICIAN SIGNATURE _____ DATE _____

PRE-AUTHED BY _____ DATE _____
INS COMPANY CONTACT _____ AUTH # _____

INS COMPANY COMMENTS _____
_____
_____