PIEDMONT COMMUNITY HEALTH PLAN
Community Partners for Quality Healthcare

DME Request Coversheet

This form is for <u>Out of Network Providers</u> and should be faxed to (434) 947-4465.
Please include the DME Prescription and all pertinent documentation in support of the need for the DME.
In Network providers, attach all documents to an appropriate entry in the Electronic Referral System (ERS).

NOTE: For all PCHP plans, DO NOT MARK THIS REQUEST AS URGENT/EXPEDITED UNLESS the member's provider feels that, "…applying the standard time for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function." (CMS Medicare Managed Care Manual, Chapter 13, Section 50.1)

SECTION A. MEMBER INFORMATION			
Member Name:			
Member Number:		Member DOB:	
SECTION B. DME Supplier Information			
Company Name:			
Contact Name:			
Contact Phone Number:			
Contact Fax Number:			
Request For:	☐ NEW EQUIPMENT ☐ REPLACEMENT EQUIPMENT ☐ ONGOING SUPPLY		
Equipment Agreement Type:	☐ RENTAL ☐ PURCHASE		
SECTION C. REQUEST DETAILS *(Mark "N/A" if not applicable)*			
Requesting Authorization For:			
HCPC Codes:			
Diagnosis Code(s):			
Applicable Date Span:			
Do not requests date spans of greater than 1 year. *In specific circumstances, date spans up to 1 year may be approved with applicable documentation for on-going supplies.*			
Additional Information			