Care Management Services
PO Box 663, Westborough, MA 01581
Phone: 866-325-1550
Fax: 508-756-1382

DME Authorization Request Form

Vendor: Tax ID#:

Fax: From:

Phone: Ext. Date:

Re (Patient): Member ID#:

Patient D.O.B.: Dx: ICD-9:

Pages *(including cover)*:

						For CMS Use Only
DME Item *(if over $1000)*	**Code**	**Date(s) of Service**		**Quantity**	**Cost** *(each)*	**Health Plans Case#**
		From	**To**			

Consideration of this request is based upon current information submitted for review. A case number does not guarantee payment; claims payment is dependent on the patient's eligibility at the time services are rendered, the patient's benefits as stated in the plan document, retrospective review of clinical data, and the required documentation of the service(s) provided.

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