UnitedHealthcare®
Community Plan

# Durable Medical Equipment (DME) Prosthetics Orthotics and Supplies Request Form

Expedited/urgent requests may be made by members or network care providers and must to include the ordering physician's prescription or order. By asking for an urgent request, you acknowledge that waiting for a decision under a standard timeframe could endanger the member's life, health, or ability to regain maximum functionality or would cause serious pain.

To submit the request, please complete all the fields in the form and fax it to the appropriate number noted in the table at the bottom of the page. Please include all relevant clinical data to support the request for services including prescriptions from the ordering physician. If you don't provide enough information, it may delay the response to your request. For a list of DME services that require prior authorization, please visit UHCCommunityPlan.com > For Health Care Professionals > Arizona > Provider Information. If you have questions, please call the Prior Authorization Department at 866-604-3267.

## DME Vendor

Date:_____Contact person's name: _____

Phone: _____ Ext: _____Fax:_____**HIPAA secure fax line?** ☐Yes ☐No

DME care provider: _____ TIN/NPI: _____

Address: _____

Date of service: _____ ☐ In-network ☐Out-of-network

Will out-of-network care provider accept Medicaid/Medicare default rate? ☐ Yes ☐ No

## Member Information

Member name:_____Member ID#:_____Date of birth: _____

Member preferred phone number: (_____) _____

**Does the member have other insurance**? ☐ Yes ☐ No **If yes,** Medicare ☐ Part A ☐ Part B

**Other insurance name and policy #**_____

## Ordering Physician

Date:_____Contact person's name: _____

Ordering physician: _____ TIN/NPI: _____

Address: _____

Phone: _____ Ext: _____Fax:_____**HIPAA secure fax line?** ☐Yes ☐No

Date of service:_____ ☐ In-network ☐ Out-of-network

Will out-of-network care provider accept Medicaid and/or Medicare default rate? ☐ Yes ☐ No

## Clinical Information

Clinical documentation attached: ☐Yes / ☐No Prescription: ☐Yes / ☐ No

Diagnoses code:_____

Healthcare Common Procedure Coding System (HCPC) code(s):_____

_____

_____

Miscellaneous and/or unlisted codes **description required**: _____

_____

DME Cost: $_____ ☐ Rental ☐ Purchase ☐ Renewal Request

Start date:_____End date:_____

***Please return the completed form by secure fax to the number that corresponds with the member's state of enrollment:***

| | | | |
|---|---|---|---|
| Arizona: 888-899-1499 | Kansas: 866-943-6474 | Nebraska: 866-622-1428 | Rhode Island: 866-950-7757 |
| Delaware: 877-877-8230 | Massachusetts: 888-840-6450 | New Jersey: 888-840-9284 | Tennessee: 800-743-6829 |
| Florida: 866-607-5975 | Maryland: 888-899-1681 | New York: 866-950-4490 | Texas: 877-940-1972 |
| Hawaii: 800-267-8328 | Mississippi: 888-310-6858 | Ohio: 866-839-6454 | Washington: 855-554-2152 |
| Iowa: 888-899-1680 | Michigan: 855-225-9847 | Pennsylvania: 877-310-3826 | Wisconsin: 800-897-8317 |