

DME Request

DOC TYPE 0V

RMHP Statewide Fax: 877-201-7302 or 970-254-5738

Date Request Submitted: _____

New Request Revised Request — Original Reference # _____

To ensure your pre-service request is completed in a timely manner, please allow:

Medicaid — 10 days Medicare — 14 days CHP+ — 15 days Commercial — 15 days

Member Name: _____ ID #: _____ DOB: _____

Requesting Physician (Please use full name): _____

Diagnosis: _____ ICD-9 Code: _____

Billing Provider/Vendor: _____ TIN: _____

City/Location: _____

Person completing this form: _____

Phone #: _____ Ext: _____ Fax #: _____

Please provide clinical information with the request to avoid processing delays.

HCPSC Code	Description of Item	Quantity	Price	Rental Date of Service Begin Date/End Date		Purchase Date of Service	

The preauthorization for services noted in this form is only for the time period during which the patient remains eligible on the patient's current health benefit plan or for a shorter period as specified in this form. Rocky Mountain Health Plans is not financially responsible for the services that are preauthorized if the patient is not eligible on the date services are provided. Further as permitted by applicable law, this preauthorization is subject to concurrent review as to medical necessity, appropriateness or efficacy, and coverage for services being provided and is subject to the terms and conditions in the Member's Evidence of Coverage, including but not limited to, coordination of benefit provisions, preexisting conditions and limitations, and any agreements between Rocky Mountain Health Plans and the health care provider. Billing for the services preauthorized on this form is subject to nationally standardized rules for coding and paying health services as used by Rocky Mountain Health Plans.

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