



## DME Request

DOC TYPE 0V

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

**WINhealth Partners Fax: 877-825-3018**

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

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

Member Name: \_\_\_\_\_ ID #: \_\_\_\_\_ DOB: \_\_\_\_\_

Requesting Physician (Please use full name): \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

Vendor: \_\_\_\_\_ City/Location: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Person completing this form: \_\_\_\_\_ Phone/Ext: \_\_\_\_\_

HCPCS 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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