



## DME PRIOR AUTHORIZATION REQUEST FORM

THIS FORM IS FOR USE BY SUPPLIERS OF DME & RESPIRATORY EQUIPMENT, MEDICAL-SURGICAL & OSTOMY SUPPLIES, PROSTHETIC, ORTHOTIC AND HEARING AID SERVICES TO OBTAIN NHP PLAN PRIOR AUTHORIZATION (PA).

**Please contact the NHP Customer Care Center at phone 800-462-5449 to verify benefits and eligibility**

Please fax this completed form with medical justification to the  
NHP DME Authorization Team at FAX# 617-526-1935

To contact the NHP DME Authorization Team call Phone# 800-462-5449 and choose voice menu options: #4 (providers), then #1 (authorizations) and then #1 again (DME).

Please use the NHPNet Provider Site to check the status of authorizations at <https://nhpnet.nhp.org>

**Today's Date:**

<b>Member Name:</b>  <b>DOB:</b>	<b>Member ID#:</b>
<b>Delivery Address:</b>	<b>Weight:</b>  <b>Height:</b>
<b>Phone# at delivery location:</b>	<b>Family Contact Name / Relationship:</b>  <b>Family Contact Phone:</b>
<b>Ordering Clinician Name:</b>  <b>Ordering Clinician Phone:</b>	<b>Diagnosis:</b>  <b>ICD-9:</b>
<b>Service Provider Name:</b>  <b>Business Location :</b>	<b>NPI#:</b>  <b>NHP Provider ID# :</b>
<b>Staff Contact Name:</b>	<b>Phone:</b>  <b>Fax:</b>
<b>First Date of Service:</b>  <b>Actual or Proposed (please circle)</b>	<b>Previous NHP Auth.# (if any):</b>

### DME / ORTHOTIC / PROSTHETIC / MEDICAL or RESPIRATORY SUPPLY / OXYGEN DETAILS:

*PLEASE SPECIFY THE QUANTITY NEEDED for a THREE MONTH PERIOD or clearly denote "MONTHLY AMOUNT".*

Service Code: (HCPCS)	Service Description :	Rent (✓)	Purchase (✓)	Requested Quantity:

*If DME, medical supplies or nutritional formulas are needed to facilitate a hospital discharge during evenings, weekends or legal holidays those covered services can be authorized if medically necessary when a PA request is received before the end of the next business day.*

## DME PRIOR AUTHORIZATION REQUEST FORM

(Page #2 of 2)

[OPTIONAL PAGE – PLEASE USE IF ADDITIONAL SERVICES ARE NEEDED]

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NHP DME Authorization Team at FAX# 617-526-1935

<b>Member Name:</b>  <b>DOB:</b>	<b>Member ID#:</b>
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ADDITIONAL DME / MEDICAL SUPPLY DETAIL:

**PLEASE SPECIFY THE QUANTITY NEEDED for a THREE MONTH PERIOD or clearly denote “MONTHLY AMOUNT”.**

Service Code: (HCPCS)	Service Description :	Rent (✓)	Purchase (✓)	Requested Quantity:

**Comments:**

*If DME, medical supplies or nutritional formulas are needed to facilitate a hospital discharge during evenings, weekends or legal holidays those covered services can be authorized if medically necessary when a PA request is received before the end of the next business day.*