DME RE-CERTIFICATION FORM

PHONE: 866-248-1972
LOCAL: 570-271-7127
FAX: 570-271-7171

*DME VENDOR: *GHP PROVIDER #:	*LOCATION:	*PHONE: *FAX:	*FORM COMPLETED BY:

*MEMBER INFORMATION: (Last Name, First Name, MI)	*HEALTH PLAN ID:	*BIRTHDATE:

ADDRESS: *CURRENT PHONE:	*ORDERING PHYSICIAN: (Last Name, First Name)	*PHONE: *FAX:

DIAGNOSIS INFORMATION:	
*ICD-9 CODE:	DESCRIPTION:
ICD-9 CODE:	DESCRIPTION:
REQUESTED INFORMATION:	
REQUESTED EQUIPMENT: (use extra codes sheet as necessary)	

VENDOR REQUEST			**FOR INTERNAL USE ONLY**			
*HCPCS/ MODIFIER	*AUTHORIZATION NUMBER	*QTY	HCPCS/ MODIFIER	QTY	START DATE	END DATE

***Required Information. Incomplete forms will be returned unprocessed.**

Precertification authorization verifies medical necessity criteria have been met and is not a guarantee of payment.