



# DME Request Form (For Prior Authorization)

Date: \_\_\_\_\_ Name of person completing form: \_\_\_\_\_

<b>Medical Management</b> Phone number: 1-800-642-4168 • Fax numbers: (614) 785-0736, 1-866-449-6843 Molina Healthcare of Ohio, Inc. <i>Attention: Authorization</i> , P.O. Box 349020, Columbus, OH 43234-9020					
<b>Member Information</b>					
Member Name (Last, First, MI)		Date of Birth	Member I.D.		
Address: (No., Street, City, State, Zip)			Phone Number:		
<b>Referring Provider Information</b>					
Requesting Provider name: (Last, First)		Specialty:	Phone Number:		
Address: (No., Street, City, State, Zip)			Fax Number:		
<b>Referred to Provider Information</b>					
Referred to Provider Name: (Physician, Facility, Agency)		Specialty:	Phone Number:		
Address: (No., Street, City, State, Zip)			Fax Number:		
<b>Request Information</b>					
Service is: <input type="checkbox"/> <b>MEDICALLY EMERGENT</b> (Needed within 72 hrs) <input type="checkbox"/> Elective/Routine  <input type="checkbox"/> Medical Supplies <input type="checkbox"/> Orthotics <input type="checkbox"/> Prosthetics <input type="checkbox"/> Durable Medical Equipment <input type="checkbox"/> Other (please be specific) _____ Estimated length of need: _____ _____		<input type="checkbox"/> New Order <input type="checkbox"/> Replacement <input type="checkbox"/> Rent to Own  Date of Original (if known) _____ _____		<input type="checkbox"/> Repair over \$100.00  Type of equipment: _____  Repair needed: _____ _____ _____ _____	
<b>Quantity</b>	<b>Description, Make &amp; Model</b>		<b>HCPC</b>	<b>ICD</b>	<b>CPT</b>
Clinical Indications for Request: (May attach clinical or progress notes. Please include pertinent medical history and degree of impairment).					
Requesting Provider Signature:		Date Member Seen:		PCP Name:	
<b>FOR MOLINA USE ONLY</b>					
Authorization status: <input type="checkbox"/> <b>Approved</b> <input type="checkbox"/> <b>Pending</b> <input type="checkbox"/> <b>Denied</b>		Comments:			
Nurse Reviewer Signature:				Date:	
Medical Director Signature:				Date:	