allcare health

Changing healthcare to work for you.

PRIOR AUTHORIZATION / DME REQUEST FORM

☐ STANDARD REQUEST (within 14 calendar days)
☐ EXPEDITED REQUEST (as to not seriously jeopardize the member's health)(within 72 hours)
**REQUIRES PROVIDER JUSTIFICATION: _____

INSURANCE PLAN: ☐ AllCare CCO ☐ AllCare Advantage

MEMBER:
First Name: _____ Last Name: _____
DOB: _____ ID# _____

PROVIDER:
Ordering Provider: _____ Fax: _____
(please provide full name of Provider)

Rendering Facility: _____ NPI: _____
Phone: _____ Fax: _____

Place of service: Inpatient / Outpatient Hospital / ASC / In-Office / Home

SERVICE:
Requested Item/Procedure(s): _____

Diagnosis Code: _____ Diagnosis Code: _____
Diagnosis Code: _____ Diagnosis Code: _____

HCPC/CPT Code: _____	MOD: _____	Units: _____
HCPC/CPT Code: _____	MOD: _____	Units: _____
HCPC/CPT Code: _____	MOD: _____	Units: _____
HCPC/CPT Code: _____	MOD: _____	Units: _____

Start Date: _____ End Date: _____
Date of Service: _____
Additional information and/or comments: _____

PREPARED BY:
Name: _____ Clinic name: _____ PH: _____
Fax: _____ Date: _____

PLEASE FAX COMPLETED FORM WITH SUPPORTING DOCUMENTATION TO 541-471-4128.

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Grants Pass, OR 97526
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Fax (541) 471-4128
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