PASSPORT HEALTH PLAN (PHP)
DME Prior Authorization Form

Patient Information	**Passport Health Plan Ordering MD**
Patient Name:	MD Name:
PHP ID or SSN:	Address:
Date of Birth:	Phone Number:
Primary ICD 9 diagnosis	Fax:
Secondary ICD9 diagnosis	

DME PROVIDER INFORMATION

Company:	Contact Person:
Address:	Phone Number:
City: State:	Fax Number:
Zip Code:	Date submitted:
PHP DME Provider #	DOS requested:

Line Item Breakout for DME billable charges				
Line #	Description	HCPCS	Retail cost	Quantity
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Please attach documentation on the patient's abilities and limitations as they relate to the need for the equipment.

*A physician signed CMN or order is also required before any authorization can be issued.

Authorization Number ______________________________

Approved By ______________________________

Fax DME Requests to: 502-585-7990 Please call 1-800-578-0636 ext. 7310 with any questions of for further information

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