



MedicareBlueSM PPO

A Medicare Advantage Plan

Medical Management
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P.O. Box 64265, Route R4-18 • St. Paul, MN 55164-0560

DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLY PRIOR AUTHORIZATION REQUEST

To be completed and submitted by DME vendor:
Contact Person/Person Completing Form:

_____	Date: _____
DME Provider: _____	Patient Name and Birthdate: _____
_____	Member/Enrollee: _____
Provider Number: _____	Address: _____
Address: _____	_____
_____	Group Number: _____
Fax: _____	Identification Number: _____
Telephone: _____	Diagnosis: _____

Note: Complete entire form and include all narrative descriptions, charge information or the Manufacturer's Suggested Retail Price, itemized HCPCS codes, and attach Medical Necessity documentation.

<u>HCPCS Codes</u>	<u>Narrative Description</u>	<u>Charge Information/MSRP</u>
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Coverage Reply: _____ **Case Number** _____

Medicare Blue PPO Medical Management has approved the service requested as medically necessary, however this does not guarantee payment of the claim. Final payment of benefits is based on the contract that is in force on the day services are received and whether premiums have been paid, lifetime or benefit maximums have been exceeded, the condition treated is not a pre-existing condition, the service authorized is the service billed and the provider is eligible for reimbursement. Failure to use a Participating Provider may result in additional financial liability.

For specific member/patient benefit information, you must call the customer service or provider service numbers listed on the back of the membership identification card.

Comments: _____

Signature Date Phone Number

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*Independent licensees of the Blue Cross and Blue Shield Association.