



**Durable Medical Equipment (DME) Prior Authorization Request Form**

Submit completed form and supporting documentation to [UtilizationManagement.OSUHealthPlan@OSUMC.edu](mailto:UtilizationManagement.OSUHealthPlan@OSUMC.edu) or fax to (614) 292-2667.

<b>General Information</b>			
Covered Person (Patient) Name:		ID Number:	DOB:
<b>Physician Information</b>			
Physician Name:		Phone:	Fax:
<b>Vendor Information</b>			
Vendor Name:		Address:	
TIN:		Contact Name:	
Phone:		Fax:	
<b>Billing Information</b>			
ICD-10 Code(s):		Diagnosis:	
HCPCS Code(s)/Units:			
Code	Units	Price	Description
Total Price:			
Date Span Requested:			
If this is a continuation request, provide the previous authorization number:			

NOTICE: This message is intended for the use of the individual(s) to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify the sender immediately and delete the related message.