



**DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLY
PRIOR AUTHORIZATION REQUEST Date: _____**
To be completed and submitted by DME Vendor

Mail form to: Health and Wellness Services P.O. Box 179; Duluth, Minnesota 55801-0179
Fax form to: 1-866-938-9754

Provider Information	
DME Provider:	Ordering Physician (MD):
NPI #:	NPI #:
Provider Number:	Provider Number:
Address:	Address:
Fax:	Fax:
Contact Name/Phone #:	Contact Name/Phone #:

Patient Information	
Patient Name:	Subscriber/Enrollee:
DOB:	Group Number:
Address:	Identification Number:
	Phone #
	Diagnosis:

HCPCS Codes	Narrative Description	Charge Information/MSRP

*****Please attach relevant medical documentation***
For prompt processing of your request – please complete ALL fields**