



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

Mail form to: Integrated Health Management, Route 472, P.O. Box 64265; St. Paul, Minnesota 55164-0265
 Fax form to: (651) 662-2810

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*****