Prior Authorization Request

For Durable Medical Equipment/Orthotics & Prosthetics (DME/O&P) Items and Services

All DME/O&P items or services require prior authorization to be rendered.

Instructions for Completing this Request

Submit this completed form to MVP Health Care® via email to **authorizationrequest@mvphealthcare.com** or by fax to **1-888-452-5947**. All supporting medical documentation and/or any additional pertinent information should be included when submitting this form.

Payment for services/items dispensed will be denied when prior authorization has not obtained. The Member may not be billed under these circumstances.

Call **1-800-684-9286** for DME/O&P-related questions. To download the DME Prior Authorization code list, visit **mvphealthcare.com/providers** and select *Reference Library*, then *Durable Medical Equipment Prior Authorization List*.

Section 1: MVP Member Information

*(*Required Information)*

Member Name* | Date of Birth* | MVP Member ID No.* | Vermont Resident?* ☐ Yes ☐ No

Is this Request a clinical emergency?* ☐ Yes ☐ No

Section 2: Requesting Provider Information

*(*Required Information)*

Requesting Provider Name* | NPI No.* | Tax ID No.* | MMIS No. *(Medicaid/CHPlus Only)*

Office Street Address* | City* | State* | Zip Code*

Phone No.* | Fax No.*

Section 3: DME/O&P Provider and Service(s) Information

*(*Required Information)*

DME/O&P Provider Name* | NPI No.* | Tax ID No.* | MMIS No. *(Medicaid/CHPlus Only)*

Office Street Address* | City* | State* | Zip Code*

Phone No.* | Fax No.*

Date of Service to be Rendered ☐ **To be Determined** | **ICD-10** Code(s)*

HCPC Code(s)	Description	**HCPC** Code(s)	Description

Item/Service Description *(check all that apply)* ☐ **Custom** ☐ **Diabetic** ☐ **Respiratory** ☐ **Routine/Other** ☐ **Orthotic & Prosthetics**

Additional Information

Name of Individual Completing Request* | Phone No.* | Is there an existing Authorization?* ☐ Yes ☐ No