GEHA®

DME Authorization

Date of request: _____

Patient name: _____ Phone: _____

ID number: _____ Date of birth: _____

Member address: _____

_____

DX: _____ ICD-10 code: _____

Billing provider information

Provider name: _____

Tax ID: _____

Address: _____

_____

Contact: _____

Phone: _____ Fax: _____

Prescribing physician: _____ NPI: _____

Items not covered under the plan:

- Computers, tablets, computer programs/games used in association with communication aides, internet or phone services used in conjunction with communication devices.
- Air purifiers, air conditioners, heating pads, cold therapy units, whirlpool bathing equipment, sun and heat lamps, exercise devices (even if ordered by a doctor), and other equipment that does not meet the definition of durable medical equipment.
- Lifts, such as seat, chair or van lifts.
- Wigs
- Devices or programs to eliminate bed wetting
- If a member is a patient in a facility other than the member's primary residence, or in a distinct part of a facility that provides services such as skilled nursing, rehabilitation services, or provides medical or nursing, DME will not be covered separately for rental or purchase.

Preauthorization (covered items under the plan)

☐ Manual wheelchair
☐ Scooter
☐ Oxygen (Desat level: _____)
☐ BIPAP
☐ CPAP replacement
☐ Oral appliance
☐ Electric wheelchair
☐ Prosthetic
☐ Continuous Glucose Monitoring System
☐ Assistive Communication Device (ACD)
☐ Other

HCPCS codes: _____ DME list price: _____

Description of equipment – manufacture/maker of equipment: _____

_____

Treatment start date: _____ Length of need: ____ days ____ months ____ years

(date equipment is placed)

Attach the following documentation:

- Letter of medical necessity and/or physician's orders
- Documentation of patient's general condition, including upper and lower body strength and activity level
- Documentation of patient status (i.e., bed confined, chair confined, ambulatory, orientation, orthopedic impairment, etc.)
- For BIPAP, reason as to why patient is not tolerating the CPAP
- For CGMS, most recent history and physical, most current A1C level, daily blood sugars for last 30 days, results of 72 hour continuous glucose monitoring test
- For Oxygen, saturation rate
- Any other additional information pertinent to your request
- Cranial helmets require color photos for review
- For CPM, provide the CPT code of the surgical procedure that relates to this request

Review of this service is pending the completion of this form. Incomplete forms will be returned; attach additional pages as needed. To avoid delay in processing your request, please provide all information requested.

IMPORTANT: Fax completed form and required documents to 816.257.3515 or 816.257.3255*

*If the patient lives in Texas, call United Healthcare Choice Plus at 877.585.9643.

Questions: Call Care Management at 800.821.6136, Ext. 3100.
Payable benefits are subject to the terms and conditions of the Health Benefit Plan.