care n care
Insurance Company, Inc.

DME Pre-Authorization Request Form

Phone: 855-359-9999
Fax: 888-965-1964

Today's Date: _____

Health Plan/Payor:

❑ Care N' Care PPO ❑ Care N' Care HMO

Patient's Name:	Birth Date: / /
Member ID#:	
DME Provider:	DME NPI:
DME Contact Person:	
DME Phone:	DME Fax:
Requesting Physician:	NPI:
PCP:	NPI:
Proposed Date of Service: / /	

RENTAL PURCHASE

ICD-10 CM Diagnosis Description	ICD-10 CM Code
Procedure: CPT/HCPCS Exact Description (one per line please)	CPT/HCPC Code (one per line please)
Describe any special circumstances which should be considered when authorizing services:	
Clinical Information/Comments: (You may attach additional clinical)	

This request will be treated as per the standard organization determination timeframes. If the request needs to be treated as expedited, clinical justification must be provided that applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function:

_____
_____
_____

Authorization does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitation, provisions and exclusions.