Pre-Authorization Request for DMEPOS

Use this form for the following plans:

● ATRIO Health Plans ● Willamette Valley Community Health (WVCH) ●

Tired of filling out this form? Submit on-line! Contact Provider Services at 503-584-2150 for CIM access

Please fax to team by members last name: Salem Clinic WVCH Fax: 503-371-4175

Alpha A-E 503-581-7353 ● Alpha F-L 503-581-7417 ● Alpha M-R 503-485-3226 ● Alpha S-Z 503-581-7422

Contact Person:	Phone #:	Fax #:	
Ordering Provider: (First, Last)	Physical Therapist: (First, Last)	Phone #:	
Client's Name: (First, MI, Last)	Recipient ID:	Client's DOB:	Client's Phone #:
Client's Mailing & Street Address:	Height: Weight:	ALF ICF SNF AFH Home Other:	

Diagnosis:_____ ICD 9:_____ Other Insurance: _____ Policy number:_____

Other DME in Home(Model, Serial # and Date Acquired:_____

Comments:_____

HCPC	Description of Equipment or Service	Make/Model or Part #	Units	@ MSRP	Allowable	Extended
		Total Amounts				

TOS: ☐ **Rental (rent to purchase)** ☐ **Purchase** ☐ **Repair** **Date Range Needed:** **to** **Original Date of Service:**

Attach Physician RX, and Medical Justification When Applicable

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HCPC	Description of Equipment or Service	Make/Model or Part #	Units	@ MSRP	Allowable	Extended
		Total Amounts				