Neighborhood Health Plan™
Your health. Our promise.

DME PRIOR AUTHORIZATION REQUEST FORM

THIS FORM IS FOR USE BY SUPPLIERS OF DME & RESPIRATORY EQUIPMENT, MEDICAL-SURGICAL & OSTOMY SUPPLIES, PROSTHETIC, ORTHOTIC AND HEARING AID SERVICES TO OBTAIN NHP PLAN PRIOR AUTHORIZATION (PA).

Please contact the NHP Customer Care Center at phone 800-462-5449 to verify benefits and eligibility

Please fax this completed form with medical justification to the
NHP DME Authorization Team at FAX# 617-526-1935

To contact the NHP DME Authorization Team call Phone# 800-462-5449 and choose voice menu options: #4 (providers), then #1 (authorizations) and then #1 again (DME).

Please use the NHPNet Provider Site to check the status of authorizations at https://nhpnet.nhp.org

Today's Date:

Member Name: **DOB:**	**Member ID#:**
Delivery Address:	**Weight:** **Height:**
Phone# at delivery location:	**Family Contact Name / Relationship:** **Family Contact Phone:**
Ordering Clinician Name: **Ordering Clinician Phone:**	**Diagnosis:** **ICD-9:**
Service Provider Name: **Business Location :**	**NPI#:** **NHP Provider ID# :**
Staff Contact Name:	**Phone:** **Fax:**
First Date of Service: **Actual or Proposed (please circle)** ☐ ☐	**Previous NHP Auth.# (if any):**

DME / ORTHOTIC / PROSTHETIC / MEDICAL or RESPIRATORY SUPPLY / OXYGEN DETAILS:

PLEASE SPECIFY THE QUANTITY NEEDED for a THREE MONTH PERIOD or clearly denote "MONTHLY AMOUNT".

Service Code: (HCPCS)	Service Description :	Rent (✓)	Purchase (✓)	Requested Quantity:
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	

If DME, medical supplies or nutritional formulas are needed to facilitate a hospital discharge during evenings, weekends or legal holidays those covered services can be authorized if medically necessary when a PA request is received before the end of the next business day.

~~~ NHP DME Authorization Team ~~~ Phone: 800-462-5449 ~~~ FAX: 617-526-1935 ~~~ (08/09)

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[OPTIONAL PAGE – PLEASE USE IF ADDITIONAL SERVICES ARE NEEDED]

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Member Name:	**Member ID#:**
DOB:	

ADDITIONAL DME / MEDICAL SUPPLY DETAIL:

PLEASE SPECIFY THE QUANTITY NEEDED for a THREE MONTH PERIOD or clearly denote "MONTHLY AMOUNT".

Service Code: (HCPCS)	Service Description :	Rent (✓)	Purchase (✓)	Requested Quantity:
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	

Comments:

If DME, medical supplies or nutritional formulas are needed to facilitate a hospital discharge during evenings, weekends or legal holidays those covered services can be authorized if medically necessary when a PA request is received before the end of the next business day.