Use for Experience Health Medicare Advantage SM (HMO)

Non-invasive Home Ventilator
Prior Authorization (PA) Request Form

(Incomplete Form May Delay Processing)

Provider Information		Member Information
Ordering Physician Name:	NPI #:	Member Name:
Office Phone#: Office Fax#:	Contact Name:	Member ID #:
Vendor Name:	NPI #:	Member's Date of Birth:
Vendor Phone #: Vendor Fax #:	Contact Name:	Member's Phone #:
ICD-10 Code(s):		

Please answer questions below

HCPCS code(s) (REQUIRED): _____

Is this request for E0465 or E0466?……..……...……. ☐ Yes ☐ No (If not, do not use this form.)

What is the start date of the rental? _ _/_ _/_ _ _ _

Does the member have a neuromuscular disease?.....……... ☐ Yes ☐ No

Does the member have a thoracic restrictive disease? ……..…… ☐ Yes ☐ No

Does the member have chronic respiratory failure consequent to COPD? ……..…… ☐ Yes ☐ No

Is there sufficient detailed documentation supporting the medical need of a non-invasive ventilator vs. the use of a CPAP or BiPAP device? ……..……..…… ☐ Yes ☐ No

Please fax supporting documentation or list rationale for use of non-invasive ventilator vs. CPAP or BiPAP device:

_____
_____
_____
_____
_____

I certify that I have appropriate authority to request an organization determination for the item(s) indicated on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Experience Health Medicare Advantage SM (HMO) may request medical records for this patient at any time in order to verify this information.

Signature:_____ Date: _____

Please Return Completed Form to:
Fax 1-919-765-7805
For questions please call Care Management at 1-833-941-0107.