Use for Experience Health Medicare Advantage SM (HMO)

Durable Medical Equipment (DME) Repair or Replacement Prior Authorization (PA) Request Form

(Incomplete Form May Delay Processing)

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

Please answer questions below

HCPCS code(s) (REQUIRED): ____

Is this a repair or a replacement? ☐ Repair ☐ Replacement

If the request is for repair:

A. Was a service evaluation completed? Please submit report for review……………………………………… ☐ Yes ☐ No
B. When did the member originally receive the item? _ _/_ _/_ _ _ _
C. Is the item currently under warranty? ………………………………………………………………………… ☐ Yes ☐ No
D. Is the cost of repair more than cost of replacement? ………………………………………………………… ☐ Yes ☐ No

If the request is for replacement:

A. When did the member originally receive the item? _ _/_ _/_ _ _ _
B. Why is the replacement needed? (i.e. normal wear and tear, natural disaster, etc.) ______________________

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C. Can the item be repaired? ……………………………………………………………………………… ☐ Yes ☐ No
D. Was the item originally purchased under Original Medicare or a Medicare Advantage plan? ……… ☐ Yes ☐ No
E. Did the member request replacement? ………………………………………………………………… ☐ Yes ☐ No
F. Did the ordering physician document a change in the member's condition and/or his/her rationale for the replacement DME? ……………………………………………………………………………… ☐ Yes ☐ No

If the request is for replacement equipment not originally covered by Original Medicare or a Medicare Advantage plan, please submit documentation that supports Medicare coverage criteria:

A. For Positive Airway Pressure device, is there a sleep study report and recent office note supporting continued use? ……………………………………………………………………………… ☐ Yes ☐ No
B. For a wheelchair, hospital bed, oxygen equipment, etc., is there an office note and/or previous certificate of

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medical necessity (CMN) available? ………………………………………………………………… ☐ Yes ☐ No

C. For a Power Mobility Device, is there an office note, seven (7) element order, product price sheet, and home assessment? ……………………………………………………………………………………… ☐ Yes ☐ No

D. For a Prosthetic, is there an office note and/or prosthetist evaluation note, documented functional level, and product price sheet? ……………………………………………………………………… ☐ Yes ☐ No

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.

Experience Health Medicare Advantage SM is a HMO plan. This plan has a Medicare contract. Enrollment in the plan depends on contract renewal.

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