



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

(Incomplete Form May Delay Processing)

Table with 2 columns: Provider Information and Member Information. Rows include fields for Ordering Physician Name, Office Phone/Fax, Vendor Name/Phone/Fax, NPI #, Contact Name, Member Name, Member ID #, Member's Date of Birth, and 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.) \_\_\_\_\_
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 medical necessity (CMN) available? ..... [ ] Yes [ ] No



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<p>C. For a Power Mobility Device, is there an office note, seven (7) element order, product price sheet, and home assessment? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>D. For a Prosthetic, is there an office note and/or prosthetist evaluation note, documented functional level, and product price sheet? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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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 Blue Cross NC may request medical records for this patient at any time in order to verify this information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please Return Completed Form to:**  
 Fax: 1-336-794-1556  
 For questions please call Care Management at 1-888-296-9790.

Blue Cross and Blue Shield of North Carolina is an HMO/PPO plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.