



Fax: Ancillary/Outpatient: 505-213-0149

Durable Medical Equipment (DME) Benefit Certification Request Form

Routine Expedited

Requesting Vendor _____ Provider# _____ Fax# _____ Date Faxed _____
Contact person _____ Phone# _____
Member Name _____ ID/SS# _____ DOB _____
Ordering Physician _____ Prescription Attached

Diagnosis (ICD-9) _____

Rental Purchase Rent to Purchase Previous Cert # _____
Requested: Effective Date _____ End Date _____

Table with 3 columns: HCPCS*, Description, #. Multiple rows for listing items.

Additional Medical Information _____

*Any unlisted code requires a dollar amount.

For request to be considered Expedited. Please read criteria below.

*Expedited/Urgent Review: Will occur when 1 of the following is present:

- (1) the life or health of a member would be jeopardized;
(2) the member's ability to regain maximum function would be jeopardized;
(3) the provider, with knowledge of the member's condition, determines that a delay in care would subject the member to severe pain that could not be adequately managed otherwise.