



<b>DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLY</b> <b>PRIOR AUTHORIZATION REQUEST    Date: _____</b> <b>***To be completed and submitted by DME Vendor***</b>
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Mail form to: Health and Wellness Services P.O. Box 179; Duluth, Minnesota 55801-0179  
 Fax form to: 1-866-938-9754

Provider Information	
DME Provider:	Ordering Physician (MD):
NPI #:	NPI #:
Provider Number:	Provider Number:
Address:	Address:
Fax:	Fax:
Contact Name/Phone #:	Contact Name/Phone #:

Patient Information	
Patient Name:	Subscriber/Enrollee:
DOB:	Group Number:
Address:	Identification Number:
	Phone #
	Diagnosis:

HCPCS Codes	Narrative Description	Charge Information/MSRP

**\*\*\*Please attach relevant medical documentation\*\*\***  
**\*\*\*For prompt processing of your request – please complete ALL fields\*\*\***