



**Durable Medical Equipment/Medical Supply
Pre-Certification / Pre-Authorization
Request Form**

(To be completed and submitted by DME vendor)

Date: _____

Provider Information

DME Provider

Ordering Provider (MD)

Name: _____

Name: _____

NPI #: _____

NPI#: _____

Provider #: _____

Provider#: _____

Address: _____

Address: _____

Phone: (____) _____

Phone: (____) _____

Fax: (____) _____

Fax: (____) _____

Contact Name/Phone #: _____

Contact Name/Phone #: _____

Patient Information

Patient Name: _____

Subscriber Name: _____

DOB: _____

Member ID #: _____

Address: _____

Group #: _____

Phone: (____) _____

Diagnosis Code(s): _____

HCPS Codes	Narrative Description	Charge Information/MSRP

- ✓ For prompt processing of your request – please complete ALL fields
- ✓ Please attach relevant medical documentation.

Fax form to: (651)662-2810 or Mail form to: Integrated Health Management,
PO Box 64668, St Paul Minnesota 55164-0668