Medical Equipment/Supply Authorization Request – Denver Health Managed Care

□MCD □MCR □POS □DHMP-A □CHP+ □CICP

Referral Number: 720-956-2339 Fax Number: 720-956-2477

| | |
|---|---|
| Date: | Provider<br>Return # |
| Authorization #: | Denial #: |
| Date Auth Given: | Date Denial Given: |
| Time Telephone Notification Given: | Time Telephone Notification given: |
| Auth given to: | Reconsideration Information given □Yes □No |
| Auth: From: To: | Denial Given to: |

| | |
|---|---|
| Caller Name: | Phone: |
| Member Name: | Phone: |
| ID#/ Medicaid #: | DOB: |
| Medical Record #: | SSN #: |
| Physician Name: | Office # |
| Effective Date: | Term date: |
| Diagnosis: | |

| **Equipment/Supplies Requested (Detailed) Please give the medical necessity for the equipment, is there Milliman criteria, if so does it met or not. Please include diagnosis (see below)** | Rental | Purchase price | Amt. Paid | Purch. Cost or Monthly Rental fee |
|---|---|---|---|---|
| □W/C □disposables □ O2 □Bipaps □Braces | | | | |
| Standard TLSO<br>Custom Jewit/aspen<br>Power chair custom | | | | |
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| | | | | |
| | | | | |
| □ COC □Services not avail at DH □provided without auth | | | | |
| | | | | |
| | | | | |
| Pt. Height: Pt. Weight: | | | | |
| Comments: | | | | |
| Staff Signature: Date: | | | | |

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| Secondary DX/Medical Necessity: |
| |
| 1. 2. 3. |
| Comments: |
| |

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|---|
| □ Pend Date: |
| □ Approved Date: |
| □ Denied Date: Reason: |
| Medical Directors Signature: Date: |
| Comments: |