SECTION A. TO BE COMPLETED BY REQUESTOR. ATTACH ALL REQUIRED INFORMATION.

DURABLE MEDICAL EQUIPMENT AUTHORIZATION REQUEST

Fax completed form to:
AHCCCS/DFSM/Tribal ALTCS
Fax: (602) 254-2426

Documents Attached:

RX- Signed Physician's order indicating the specific equipment needed and the anticipated length of need (including: Item requested, Quantity and Length of Need). A Medicare Certificate of medical necessity should be submitted, if available.

For initiation of Medical Equipment and supplies, a Face-to-Face encounter between the member and practitioner that relates to the primary reason the member requires the equipment and/or supplies is required within no more than six months prior to the start of services.

Clinical Documentation to support the medical diagnosis/ need.

Only 1 Provider quote is required if the DME has an AHCCCS capped purchase price (refer to RF112); or if Member is ***Medicare Primary/Third Party Insurance***. Quote must contain HCPCS codes, number of units and individual billing prices for all itemized equipment. ***EOB/ Denial and Delivery Ticket will need to be submitted with Claim for payment from AHCCCS.***

If the member is "***Medicaid***" ***Primary***, and the item does not have a capped purchase price (refer to RF112), you may be asked to supply to 2 Provider quotes. Quotes must contain HCPCS codes, number of units, individual billing prices for all itemized equipment.

For electric wheelchairs, orthotics/prosthetics and Communication devices, the following must also be submitted:

Assessment or evaluation conducted by a qualified professional to determine the specific DME need (for example, accessories, size, features, etc). This evaluation must be dated within the past 1 month.

If request is for "buy out" of previously rented DME, resubmit the evaluation (should be dated within 1 month prior to begin of Rental) which was originally provided when the rented DME request was submitted.

TRIBAL ALTCS PROGRAM	
CASE MANAGER NAME	
TRIBAL ALTCS PROGRAM ADDRESS	
CM PHONE NUMBER CM FAX NUMBER	
MEMBER'S NAME	
MEMBER'S DOB	
MEMBER'S AHCCCS ID	

SIGNATURES acknowledge that both Tribal ALTCS Case Manager and Supervisor have reviewed and submitted the necessary documentation to proceed with DME request.

Note: If all necessary documents are not included in the request, the packet will be returned, and a complete new packet will need to be submitted.

CASE MANAGER SIGNATURE	
DATED	
SUPERVISOR SIGNATURE	
DATED	

AHCCCS
Arizona Health Care Cost Containment System

DURABLE MEDICAL EQUIPMENT AUTHORIZATION REQUEST

1. **MEMBER'S NAME**	
MEMBER'S DOB	
MEMBER'S AHCCCS ID	
2. *(Primary Care Provider's Information)* **PCP NAME**	
PHONE #	
FAX #	
DIAGNOSIS & CODE (RELATED TO NEED)	
3. Member's Placement	❑ NF ❑ HCBS SETTING
4. Does member have **Medicare, Part B**?	❑ Yes ❑ No
5. Describe DME needed. **Be specific.**	
6. What medical conditions does member have that make requested DME necessary?	
7. What type of DME does member currently have/use for above medical condition?	
8. If request is for replacement of DME listed in #7 above, explain why current DME not repairable and/or attach cost estimate for repair.	
9. If HCBS, describe member's living arrangement and caregiver/support system.	

If additional space is needed for above questions, a separate sheet may be attached.