



**BlueCross BlueShield
of Vermont**

Independent Licensees of the Blue Cross and Blue Shield Association.



Request for Prior Approval—Durable Medical Equipment

Please FAX completed form to 802-371-3491—please be sure to FAX any clinical notes, if applicable.

SECTION 1: Patient Information

MEMBER NAME (last, first):		DATE OF BIRTH: (MM/DD/YYYY)	
ALPHA PREFIX and IDENTIFICATION NUMBER:	DIAGNOSIS CODE & DESCRIPTION:		
DATE DIAGNOSED: (MM/DD/YYYY)	PROGNOSIS:		
DATE LAST SEEN: (MM/DD/YYYY)	DATE OF SURGERY: (MM/DD/YYYY)		

SECTION 2: Attending Physician Information

ATTENDING PHYSICIAN (last, first, degree):	BCBSVT PROVIDER # OR NPI:	TELEPHONE NUMBER WITH AREA CODE:
ADDRESS:		FAX NUMBER: ()

SECTION 3: Supplier Information

NAME OF SUPPLIER & BCBSVT Provider Number or NPI:	TELEPHONE NUMBER:	FAX NUMBER: ()
ADDRESS:		CONTACT:
START DATE: (MM/DD/YYYY)	DURATION:	

SECTION 4: Equipment and Clinical Information—*all the information below is required*

HCPCS CODES:	PURCHASE PRICE:
MONTHLY RENTAL PRICE:	SPECIAL FEATURES:

MEDICAL NECESSITY OF THE REQUIRED DME (or attached clinical notes):

OXYGEN EQUIPMENT:

1. Arterial blood gas at rest and date drawn: _____
2. PO₂ levels at rest: _____
3. Oxygen saturation at rest: _____
4. Were pulmonary function studies done? If so, please include a copy of results: _____
5. HCT %, if applicable: _____
6. Frequency and duration of use (please include liters per minute and hours per day of use): _____

Please include a copy of the Certificate of Medical Necessity (CMN) and/or prescription signed by attending physician.

SECTION 5: Contact Information

NAME OF PERSON TO CONTACT REGARDING THIS FORM:	TELEPHONE NUMBER WITH AREA CODE:
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