

PASSPORT ADVANTAGE (PAD) DME Prior Authorization Form



Patient Information	Passport Advantage MD Information
Patient Name:	MD Name:
PAD ID or SSN:	Address:
Date of Birth:	Phone Number:
Primary ICD 9 diagnosis	
Secondary ICD9 diagnosis	

DME PROVIDER INFORMATION

Company:	Contact Person:
Address:	Phone Number:
City: State:	Fax Number:
Zip Code:	Date submitted:
PAD DME Provider #	DOS requested:

Line Item Breakout for DME billable charges				
Line #	Description	HCPCS	Retail cost	Quantity
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Please provide documentation on the patient's abilities and limitations as they relate to the need for the equipment.

Authorization Number _____
Approved By _____

<p>Fax DME Requests to: 502-585-7990 Please call 1-800-578-0636 ext. 7310 with any questions or for further information</p>
