Durable Medical Equipment and Medical Supplies General Prescription and Medical Necessity Review Form

Point32Health
Harvard Pilgrim Health Care TUFTS Health Plan

Tufts Health RITogether

Submit the **completed** form and required documentation for review. We encourage you to complete and submit your request using our secure portals. For details on this and other options, please refer to our How to request prior authorization webpage.

Sections **1-5** must be completed by the Durable Medical Equipment (DME) providers. Sections **4a, 4b, 5a, 6,** and **7** must be completed by member's prescribing provider.

Effective prescription date: / /

1. Member information

Name: Date of birth: / / Gender: M F

RI Medicaid # Address: Phone:

Height: Weight:

ICD code(s):

Diagnosis:

2. Prescribing provider information

Name: NPI #

Address: Phone: Fax:

3. DME provider information

Name: NPI #

Address: Phone: Fax:

4. For DME equipment only

	Items requested	HCPCS Code	Modifiers
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

For additional listing, please go to page 3, section **4b**.

4a. *Must be completed by prescribing provider or the prescribing provider's employee:*

	Length of need in months
1.	
2.	
3.	
4.	

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5. For medical suplies only

	Items requested	HCPCS Code	Modifiers
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

5a. *Must be completed by prescribing provider or the prescribing provider's employee:*

	Monthly quantity	# of refills
1.		
2.		
3.		
4.		

6. Medical justification

Medical justification for requested item(s) along with any settings, therapeutic outcomes, and previous treatment plans (*if applicable*). Please attach any **supporting documentation** (i.e., lab tests, etc.):

7. DME provider attestation

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and it is true, accurate, and complete to the best of my knowledge. I also certify that I am the provider or, in the case of a legal

entity duly authorized to act on behalf of the provider. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material contained herein. Note: Signature and date stamps, or the signature of anyone other than the provider of DME or a person legally authorized to sign on behalf of legal entity is not acceptable.

Provider of DME signature: Date:

Printed legal name of provider: Printed legal name of individual signing:

8. Prescribing provider attestation

I certify that I am the prescribing provider identified in Section 2 of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information per (130 CMR 450.204) on this form is true, accurate, and complete to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature: Date:

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4b. Additional listing (*if needed*)

	Items requested	HCPCS Code	Modifiers	Quantity
21.				
22.				
23.				
24.				
25.				
26.				
27.				
28.				
29.				
30.				

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