Itasca Medical Care (IMCare) DME Authorization Form

Submission of this form does not guarantee approval.
Forms submitted with incomplete data cannot be reviewed and will be returned to your office. Benefits are subject to eligibility at the time service is rendered.

IMCare requires manufacturer's quote for all requests and will not accept any requests for equipment in which the manufacturer's invoice has been modified or pricing has been blocked out.

Fax completed authorization request to 218-327-5545.

☐ **Standard Request** ☐ **Expedited Request**

MEMBER INFORMATION Date of Request:____________________

Name:______________________________DOB: ____________________

Member ID Number:____________________Member Phone: ____________________

REFERRED BY:

Referring Provider:____________________Facility:____________________

Phone Number:____________________Fax Number: ____________________

Address:____________________City:____________State:_____Zip:__________

DME PROVIDER: ____________________Phone Number:____________________

NPI#:____________________Fax Number: ____________________

Address:____________________ City:__________ State:______ Zip:__________

Contact Person Name/Phone: ____

☐ **FOR ALL NEW ORDERED DME:** I attest that member has had a face-to-face encounter with a physician, NP or PA within the last SIX months prior to the start of service. The visit was related to the diagnosis in which the requested durable medical equipment was prescribed and documentation of this visit will be kept as part of the member's health record in our agency.

Has the requested equipment been dispensed? Yes No If yes, when:____________________

IMCare covers rental when possible, can this item be rented? Yes No
If no, please indicate a reason why this item cannot be rented: ____________________

____

REQUESTED SPAN OF APPROVAL: Start:____________________End:____________________

ICD 10 Diagnosis Codes: __________ __________ __________ __________ __________

HCPCS Codes	# of Units/requested for date span

IMCare Office Use Only

☐ Approved ☐ Not Approved

____
Medical Director/Managed Care Nurse Signature

Date:____________________Comments/Request:______________________________

Reason for Denial: ____

PLEASE FAX RELEVANT MEDICAL DOCUMENTATION ALONG WITH THIS FORM

Revised 05/13/20