Tricare DME Prior Authorization Standard Request Form

Request Completed By: _____ Phone #:_____

Date of Request: _____

Ordering Provider Information:

Physician Name: _____

Address: _____

Phone #: _____ Fax #: _____

Vendor Information:

About You

Address: 3401 Henderson Blvd Ste A

Tampa, FL 33609-3988

YIN/NPI# 1033462171

Phone #: (480) 840-4120

Fax: (480) 907-3092

PURCHASE/SUPPLY REQUEST **MODIFICATION TO EXISTING DME**

HCPCS Code	Description of Ordered Product		Quantity (Items)
E0676	NOS Intermittent Limb Compression		1
ICD 10 CODE: Z34.90			

REQUEST SUBMITTED BY:

SIGNATURE OF PATIENT REQUESTING INFORMATION:

_____ DATE: _____

PHYSICIAN SIGNATURE: _____ DATE: _____