

From

From _____ Fax _____ Phone _____ Date _____
E-mail _____

Member Information

Last, first MI _____
Medicaid ID # _____ DOB _____

Procedure Information

Please select **ONE** of the following: DME Medical supplies
Diagnosis _____ Service start _____ Service end _____
ICD9 code _____ HCPCS code _____ Quantity _____ Purchase Lease

Provider Information

Provider name: last, first MI _____ Provider ID # _____
Address, city, state zip _____
Contact person _____ Fax _____ Call back # _____

Practitioner Information

Practitioner name: last, first MI _____ State ID # _____
Address, city, state zip _____
Contact person _____ Fax _____ Call back # _____

FAX request form with supporting clinical documentation to 866.368.4562.

Select Health Use Only

Case number _____ Date _____
Given by _____ Ext. _____