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 Franklin, Wisconsin 53132  
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 Facsimile 1-414-325-3978



## EqualityCare DME Prior Authorization Form

I. PATIENT INFORMATION				II. PROVIDER INFORMATION	
1. DOB	2. SEX	3. AGE	4. EQUALITYCARE ID#	9. NPI NUMBER	10. TAXONOMY
5. PATIENT NAME (LAST, FIRST, MI)				11. PROVIDER NAME	
6. STREET ADDRESS				12. STREET ADDRESS	
7. CITY, STATE, ZIP CODE				13. CITY, STATE, ZIP CODE	
8. TELEPHONE NUMBER				14. TELEPHONE NUMBER CONTACT NAME	
III. SERVICE INFORMATION				15. DATE(S) OF SERVICE MM/DD/YY	
				FROM	TO
16. PROPOSED MEDICAL SUPPLIES, PHARMACY, SURGICAL PROCEDURES OR OTHER SERVICES, (LIST PRIMARY PROCEDURE FIRST)			17. PROCEDURE, NDC OR REVENUE CODE(S)	18. UNITS	19. ESTIMATED COST
20. TREATING PROVIDER NPI NUMBER					
A.					
B.					
C.					
D.					
21. SUMMARY OF HISTORY (DIAGNOSIS, DATE OF ONSET, PROGNOSIS, PHYSICAL EXAMINATION, LABORATORY, X-RAY STUDIES, PHARMACY, AND APPLICABLE DOCUMENTATION MUST BE SUPPLIED IN SUFFICIENT DETAIL TO SATISFY THE MEDICAL NECESSITY FOR THE PRESCRIBED SERVICE. ADDITIONAL DOCUMENTATION MAY BE ATTACHED WHEN NECESSARY.)					
22. REFERRING WYOMING PHYSICIAN:			TELEPHONE NUMBER:		
(IF THIS AUTHORIZATION REQUEST IS FOR SERVICE TO BE RENDERED OUT-OF-STATE, A BRIEF JUSTIFICATION STATEMENT IS REQUIRED)					
23. VERBAL AUTHORIZATION GIVEN BY:			DATE:		PA NUMBER:
24. TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.					
SIGNATURE OF PROVIDER:				DATE:	
IV. AUTHORIZATION (FOR STATE USE ONLY)					
AUTHORIZATION IS VALID FOR SERVICES		25. FROM DATE:		26. TO DATE:	
27. PRIOR AUTHORIZATION NUMBER:					
28. COMMENTS/EXPLANATION:					

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO THE PATIENT'S ELIGIBILITY AND WYOMING BENEFIT LIMITATIONS. BE SURE THE EQUALITYCARE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICES.