



NEW HAMPSHIRE MEDICAID



SCHALLER ANDERSON
MEDICAL ADMINISTRATORS,
INCORPORATED

**DURABLE MEDICAL EQUIPMENT (DME)/MEDICAL SUPPLY
PRIOR AUTHORIZATION REQUEST**

*****PLEASE PRINT OR TYPE ALL INFORMATION*****

RECIPIENT NAME: _____ RECIPIENT MEDICAID ID #: _____

PROVIDER INFORMATION

DATE OF REQUEST: ____/____/____ CONTACT PERSON: _____
 PROVIDER NAME: _____ NH MEDICAID PROVIDER #: _____
 ADDRESS: _____ CITY/STATE/ZIP: _____
 TELEPHONE #: _____ FAX #: _____
 ICD-9 CODE(S): _____ ORDERING PHYSICIAN: _____

WRITTEN DIAGNOSIS: _____

EQUIPMENT/MEDICAL SUPPLY INFORMATION (indicate N/A if it doesn't apply to your request)

ITEM/SERVICE REQUESTED	PROCEDURE CODE	NUMBER OF UNITS	ACQUISITION COST (PER UNIT)	MANUFACTURER'S SUGGESTED RETAIL	MONTHLY RENTAL CHARGE	DATES OF SERVICE (START-END)	NEW OR USED

You must indicate your costs for each item/service listed. For equipment, you must also indicate if the item requested for **purchase** is new or used. If the equipment you are offering to **sell** is "used," you must indicate the make/model and year of manufacture, as well as any warranty for parts or labor, on this form. You must also indicate the expected life of the equipment given its present condition. Be sure to attach any written documents you deem necessary for the processing of this request for determining if medical criteria are met.

"I certify that the above items/services will be provided and that documentation regarding our acquisition costs reflects best price (usual & customary pursuant to Section 126-A:3), as well as the certificate(s) of medical necessity (including the physician's signed prescription, when appropriate), are attached for review by NH Medicaid Prior Authorization staff."

DME or Medical Supply Provider Signature

Date

Print

Name/Title

Title

CERTIFICATION OF MEDICAL NECESSITY

Pursuant to He-W 571.06, to document the medical necessity for the item/service requested above, the **written** diagnosis and supporting clinical information **must be attached and included** with your request, and be **signed** by a PCP or treating physician/ARNP.

PLEASE FORWARD THIS INFORMATION TO SCHALLER ANDERSON BY FAX OR MAIL

Please submit supporting documentation for verification of above information

Approval is a determination that the services requested are medically necessary and not a guarantee of payment.

53 Regional Drive ■ Suite 201 ■ Concord, NH 03301 ■ FAX: (866) 499-9334 ■ PHONE: (866) 499-9335