



PHP CARE COMPLETE FIDA-IDD PLAN's DME POS REQUEST FORM

Participant Name: _____ Participant ID #: 450000 _____ (fill in last 7 digits)
Sex: _____ DOB: _____ Phone Number: (____) _____ Address: _____
_____ County of _____
Residence: _____ Participant Representative: _____
Phone Number: (____) _____ Address: _____
_____ Phone: (____) _____

Requesting Provider Name: _____ NPI: _____
Address: _____
Phone Number: (____) _____ Extension: _____
Contact Name (person completing form): _____
Phone Number: (____) _____ Extension: _____

DME -POS Being Requested: _____
HCPCS: _____
Pertinent Diagnosis Code (s): _____
Pertinent Diagnosis Description: _____

Please fax completed form, along with SCRIPT, LETTER OF MEDICAL NECESSITY and CLINICAL DOCUMENTATION to: 646-892-4810 For questions, please call 855-747-5483