PHP PARTNERS HEALTH PLAN

PHP CARE PREFERRED - DME POS REQUEST FORM

Participant Name:_____ **Participant ID #:** _____

Sex:_____ **DOB:**_____ **Phone Number: (**_____**)** _____

Address:_____

County of Residence:_____

Requesting Provider Name:_____ **NPI:**_____

Address:_____

Phone Number: (___**)**_____ **Extension:** _____ **Fax Number (**___**)** _____

Ordering Vendor Name: _____ **NPI:** _____

Address: _____

Phone Number: (____**)**_____ **Extension:** _____ **Fax Number: (**___**)**_____

Contact Name (person completing form):_____

Phone Number: (____**)**_____ **Extension:**_____

Primary ICD-10 Code: **Description:**

Plan Date of Service: From: -----/----/----- To: ----/----/----

HCPCs Code:	Description of Procedure Service	Units	Amount Billed

This form must be accompanied by an appropriate SCRIPT and if required additional information such as LETTER OF MEDICAL NECESSITY / CLINICAL DOCUMENTS to support the requested service(s).

FAX TO (646) 948-1027 For questions, please call 855-747-5483