



Suggested
PMD Prior Authorization
Cover Sheet



To: DME MAC for Beneficiary Living in CA
Fax number: 555-555-5555

For HCPCS: _____

Beneficiary Name:

Beneficiary HICN:

Physician (Practitioner) Name:

Physician (Practitioner) NPI:

Physician (Practitioner) Address:

- Initial Request
 Resubmission
 Expedited Request

Submitter Contact:

Name: _____

Phone: _____

Email: _____

Number of Pages Including Cover
Sheet: _____

Date: _____

Supplier Name:

Supplier NPI:

Supplier PTAN:

Supplier Address:

___ **A. Face-to-Face examination progress note**

___ **B. 7 Element Order**

___ **C. Detailed Product Description**

___ **D. Other Relevant Medical Documentation**