

Durable Medical Equipment Referral Worksheet

Attn: Medical/Surgical-Pre-D Coordinator

Phone Number: 1-800-891-2520

Fax: 567-661-0846

Date of Request: _____

Member Name: _____

Paramount ID# _____

DOB: _____

Paramount Secondary ID#: _____
(if applicable)

Requesting Physician: _____

Contact Person: _____

NPI: _____

Provider Billing Tax ID (TIN): _____

Phone Number: _____

Fax Number: _____

Diagnosis: _____

ICD-10 Code: _____

HCPCS Codes: _____

Continuation of Care Request (Concurrent Review): Yes: _____ No: _____.

If yes, please include previous authorization approval number: _____

.....

Date Dispensing of Item: _____

Company Name Dispensing DME Item: _____

NPI #: _____ Tax ID#: _____

Address: _____

Telephone Number: _____

Fax Number: _____

Name of Person Completing Form: _____ Phone Number: _____

Fax Number: _____

.....

Please send the following information

- Brief medical/clinical history
- Current signs and symptoms
- Results of any pertinent diagnostic testing

****PLEASE NOTE PARAMOUNT IS NO LONGER ABLE TO REVIEW FOR RETRO DATES OF SERVICE ****

CONFIDENTIALITY NOTICE The documents accompanying this fax transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.