



**Utilization Management**  
**Phone No.: 1-877-284-0102      Fax No.: 1-800-510-2162**

HealthLink Durable Medical Equipment—Stimulators Pre-Review

**DME review is required for rental or purchase that will be greater than \$1000**

Date: \_\_\_\_\_ Notification # \_\_\_\_\_ (provided after initial review)  
*A Utilization Management representative will fax you a notification number by the next business day after receiving this completed form. This notification number does not indicate an approval or denial of benefits, but only proof that the Plan has been notified. This information will be forwarded to the Plan's Managed Care department. If you have any questions, please call Healthlink at 1-877-284-0102.*

**Provider Information**

Provider's Name: \_\_\_\_\_  
Address \_\_\_\_\_  
Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

**Patient Information**

Patient's Name \_\_\_\_\_  
ID Number \_\_\_\_\_ Patient's DOB: \_\_\_\_\_  
Address \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Daytime Phone No. \_\_\_\_\_

**Ordering Physician Information**

Physician's Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone No. \_\_\_\_\_ Fax No. (Required) \_\_\_\_\_  
TIN: \_\_\_\_\_

**Treatment Information**

Diagnosis & Past Medical History (please include previous treatments and dates): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of injury and/or surgery: \_\_\_\_\_

Is this injury work related? Yes  No   
Is this injury a result of a motor vehicle accident? Yes  No

Functional Status: (specify) \_\_\_\_\_  
\_\_\_\_\_

Where does the patient reside? Home  SNF  Other  (specify) \_\_\_\_\_

Equipment Start Date \_\_\_\_\_ New  Used

How long will the patient require this equipment?  
# \_\_\_\_\_ Weeks # \_\_\_\_\_ Months \_\_\_\_\_ Indefinite

\* Type(s) of Medical Equipment with HCPC code and prices:

Type	HCPC	Purchase	Rental	Circle One
		\$	\$	per D / W / M
		\$	\$	per D / W / M
		\$	\$	per D / W / M
		\$	\$	per D / W / M

**Contact Information**

Contact Person \_\_\_\_\_

Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

Staff Signature/Title: \_\_\_\_\_ Date: \_\_\_\_\_

*\*Preferred provider available for DME and HI services*

Benefits depend upon the eligibility of the patient at the time of admission, subject to all other Plan limitations, pre-admission review requirement and prior related claims. Verification of eligibility and description of benefits are based upon the information we have on file and does not guarantee payment.