WellFirst Health®

Durable Medical Equipment Authorization Form
Fax completed form to: 608-252-0863

PATIENT DEMOGRAPHICS		
Patient Name:		Date of Birth:
Member ID:		Phone Number:
Street Address:		
City:	State:	Zip Code:

REFERRING PROVIDER INFORMATION		
Provider Name:		Phone #:
Street Address:		Fax #:
City:	State:	Zip Code:
Provider #:	Specialty:	

REFERRED TO PHYSICIAN/FACILITY/PROVIDER INFORMATION		
Referred To:		Phone #
Street Address:		Fax #
City:	State:	Zip Code:
Specialty:		

REQUESTED DATE OF SERVICE	DIAGNOSIS/ICD CODE(S)	
	1.	3.
	2.	4.

Equipment Information				
Type of Equipment	**HCPCS**	**Quantity**	**Rental or Purchase**	**Price**
Comments:				

Form Submitted By:		
Name:	Phone:	Fax:

The completed form can be faxed to: 608-252-0863

If you have any questions regarding the services or form, please contact our Customer Care Center at 866-514-4194 or review wellfirstbenefits.com. An approved prior authorization is required before obtaining services from non-plan providers.