

☐ Medical Access Program ☐
Medical Supply Request Form

Provider/Supplier Name: _____

Provider/Supplier Phone Number: () _____ Fax Number: () _____

Contact Name: _____

Member Name: _____ Recipient ID Number: _____

Prescribing Physician's Name: _____ Diagnosis Code(s): _____

1. <i>Office Use Only</i> <input type="checkbox"/> <i>covered**</i> <input type="checkbox"/> <i>not a benefit</i> <input type="checkbox"/> <i>requires review**</i> <i>Claims /Clinical</i>	Procedure/CPT Code: _____	Service/Product Description: 	Quantity: Acquired Cost: Retail Cost:
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Notes: _____

2. <i>Office Use Only</i> <input type="checkbox"/> <i>covered**</i> <input type="checkbox"/> <i>not a benefit</i> <input type="checkbox"/> <i>requires review**</i> <i>Claims/Clinical</i>	Procedure/CPT Code: _____	Service/Product Description: 	Quantity: Acquired Cost: Retail Cost:
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Notes: _____

3. <i>Office Use Only</i> <input type="checkbox"/> <i>covered**</i> <input type="checkbox"/> <i>not a benefit</i> <input type="checkbox"/> <i>requires review**</i> <i>Claims/Clinical</i>	Procedure/CPT Code: _____	Service/Product Description: 	Quantity: Acquired Cost: Retail Cost:
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Notes: _____

UPHP Representative: _____ **Date:** _____ **Time:** _____

**** All covered benefits must meet MDCH & ABW guidelines. If your request is determined to require review, please FAX this form with supporting clinical documentation and pricing information to (906) 225-7690 for medical necessity review. Benefit verifications are not authorizations and do not guarantee payment.**