Upper Peninsula Health Plan
853 West Washington Street
Marquette, MI 49855
Phone (906) 225-7500 Fax (906) 225-9269
www.uphp.com

Date of Request _____

Date of DME Order _____

DME/Medical Supply Prior Authorization Request Form

Please Include Current Supporting Documentation and a Prescription/Order from the Physician – No Retrospective Requests

☐ **UPHP Medicaid** ☐ **UPHP Medicare** ☐ **MI Health Link** ☐ **UPHP HMP** ☐ **UPHP CSHCS**

Member Name: _____ Member ID Number: _____

Member Date of Birth: _____/_____/_____ Prescribing Physician Name: _____

Urgency: Standard_☐_ Expedited_☐_ member's life/health/function in serious jeopardy

Provider/Supplier Name:_____Contact Name: _____

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

**** All covered benefits must meet CMS and/or MDHHS guidelines. The fee schedules are available at www.uphp.com.**

HCPCS Code: **Dx:**	**Product Description:**	**Quantity:** **Cost:**
Reason for Prior Authorization: ☐ **Out-of-Network Provider** ☐ **Manually Priced Item** ☐ **Hearing Aid(s)** ☐ **Diagnosis does not meet** ☐ **Purchase of capped rental** ☐ **UPHP requires PA** ☐ **Over quantity limit** ☐ **Beyond age limit**		
UPHP USE ONLY _____*Covered*** _____*Not a benefit* _____*Priced per MDHHS guidelines* _____*Priced per CMS guidelines* _____*Manually Priced item Approved Fee:* *$*_____		
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UPHP USE ONLY

AUTHORIZATION #:_____ **Start Date:**_____ **End Date:**_____

COMMENTS: _____

Approved:_____ **Denied:**_____ **Decision Date:**_____

All requests are subject to review for medical necessity, eligibility, and plan benefits at the time of service.

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DME Additional Codes

Member Name: ____ Member ID Number: ________________________

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