



Insurance Company, Inc.

Silverback Care Management

DME Pre-Authorization Request Form

PHONE: 855-359-9999

FAX: 888-965-1964

Health Plan/Payor: Care N' Care PPO Care N' Care HMO

Today's Date:	
DME Contact Name:	
DME Phone:	DME Fax:

Patient's Name:	DOB	Member ID:
Patient PCP:	NPI:	

Proposed Date of Service:	
DME Provider:	DME NPI:
Requesting Physician:	NPI:

RENTAL

PURCHASE

ICD-10 CM Diagnosis Description	ICD-10 CM Code	
Procedure: CPT/HCPCS Exact Description	CPT/HCPC Code	# of Visits

Enter any notes pertinent to this standard request. PLEASE SUBMIT CLINICAL DOCUMENTATION WITH ALL SUBMISSIONS

FOR EXPEDITED REQUESTS ONLY. Check is requesting an expedited review that meets CMS definition that determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Authorization does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitation, provisions and exclusions.

CONFIDENTIALITY NOTICE: This fax message, including any attachments, is for the sole use of the intended recipient(s) to which it is addressed and may contain confidential, privileged or proprietary information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, you are not authorized to read, print, retain, copy or disseminate this message, attachments or any part of them. If you have received this message in error, please notify the sender immediately and destroy the original message, attachments and all copies thereof.