\*The seating and mobility evaluation must be submitted with all wheelchair PA requests.

\*The Speech Generating Device (SGD) evaluation must be submitted with all SGD PA requests.

This form is to be used for all PA requests except for continuous glucose monitoring, infant formula, and wheelchair repair. Those three DME categories have specific PA forms.

**All information can be entered when submitting the request via online portal (**[**http://myqualitrac.com**](http://myqualitrac.com)**). If choosing to submit the request via fax, please fax this completed form, all required documentation, and documentation of medical necessity to (866) 539-0365.**

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| **Medicaid Participant Information** |
| Last Name: First Name: Initial: |
| Medicaid ID: Phone: DOB: |
| ICD-10 diagnosis code:  |

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| **Medicaid DME Supplier Information** |
| Supplier Name: NPI: |
| Contact Person: Email: |
| Phone: Fax: |

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| **Physician Information** |
| Physician Name: NPI:  |

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|  | **Requested Equipment – Ten Months Rental Coverts to Purchase** |
| **HCPCS**  | **Modifier** | **Description** | **Quantity** | **Price Each** | **Start Date** | **End Date** |
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| **Medicaid Supplier Acknowledgment** |
| [ ]  Supplier representative has read, agreed, and applied guidance from the most recent Idaho  DMEPOS PA Policy and Medical Criteria Manual and Supplier Handbook.[ ]  Signed Physician or Non-Physician Practitioner’s order, Letter of Medical Necessity, and all required documentation is included.[ ]  Supplier understands request for services does not guarantee payment.[ ]  Supplier understands PA requests must be complete and valid or it will be denied due to  incomplete documentation**.** [ ]  For PAs exceeding limitations, indicate how many units have already been dispensed and dates delivered. Units Dispensed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Delivered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | **Requested Equipment – Ten Months Rental Coverts to Purchase** |
| **HCPCS**  | **Modifier** | **Description** | **Quantity** | **Price Each** | **Start Date** | **End Date** |
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Attach an additional page if additional codes are needed.

* *The status of a prior authorization request may be checked via portal or by calling (866) 538-9510.*
* *Any questions regarding this process may be sent to* *IDMedicaidsupport@telligen.com*
* *More information is available at idmedicaid.telligen.com*