Division of Medical Services

PRESCRIPTION & PRIOR AUTHORIZATION REQUEST FOR MEDICAL EQUIPMENT

EXCLUDING Wheelchairs & Wheelchair Components

SECTION A - TO BE COMPLETED BY THE PROVIDER

☒ INITIAL ☐ RECERT ☐ MODIFICATION ☐ EXT OF BENEFITS	**START DATE:** TBD UPON APPROVAL
PROVIDER NAME: TOBII DYNAVOX	**PROVIDER MAILING ADDRESS:** 2100 WHARTON STREET, STE 400, PITTSBURGH, PA 15203
PROVIDER IDENTIFICATION #/TAXONOMY CODE: 152820716/332B00000X	**PROVIDER PHONE & CONTACT PERSON:**

BENEFICIARY NAME: (LAST, FIRST, MI)	**BENEFICIARY MEDICAID ID #:**	
BENEFICIARY MAILING ADDRESS:	**DATE of BIRTH:**	**SEX:** ☐ MALE ☐ FEMALE
PRESCRIBING PHYSICIAN:	**PROVIDER IDENTIFICATION #/TAXONOMY CODE:** NPI #	

PROCEDURE CODE	MOD 1	MOD 2	TOS	DESCRIPTION OF ITEMS REQUESTED	UNITS REQUESTED

I attest that the above information is true to the best of my knowledge.

PROVIDER SIGNATURE _____ DATE _____

SECTION B - TO BE COMPLETED BY THE PHYSICIAN

EST. LENGTH OF NEED: _____WKS _____ MONTHS _____PERM	**EPSDT REFERRAL:** ☐ YES ☐ NO ☐ N/A	**CURRENT HEIGHT:** INCHES	**CURRENT WEIGHT:** LBS
DIAGNOSIS & ICD CODE:	**DIAGNOSIS & ICD CODE:**	**DIAGNOSIS & ICD CODE:**	

IS THIS EQUIPMENT BEING SUPPLIED FOR USE IN THE BENEFICIARY'S HOME? ☐ YES ☐ NO

MEDICAL NECESSITY FOR REQUESTED SERVICES:

PHYSICIAN SIGNATURE _____ DATE _____

****A prescription for the requested items MUST be documented above or a separate prescription MUST be submitted. If the above documentation is insufficient to justify the requested items, a letter of medical necessity from the prescribing physician WILL be required. Please retain a copy of this form in your files.**

Send completed form to:

Arkansas Foundation for Medical Care, Inc., (AFMC) – Attn: Ami Winters

PO Box 180001

Fort Smith, AR 72918-0001

DMS-679-A (12-15-14)