MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREPAYMENT REQUEST FORM

Date (00/00/00)

Please check appropriate box:

☐ **DME** ☐ **DMS** ☐ **OXYGEN & RELATED RESPIRATORY EQUIP.**

SECTION I – RECIPIENT'S INFORMATION

Recipient's Maryland Medicaid Number

NAME (Last) (First) (MI)

DOB SEX TELEPHONE NO.

Address

City State Zip Code

SECTION II – PAY-TO-PROVIDER INFORMATION

Maryland Medicaid Provider Number

National Provider Identifier (NPI)

Provider Name & Address: _____

Contact: _____ **Telephone:** (____) _____

SECTION III – PRESCRIBER'S INFORMATION

Date of Request: _____ **Documentation of last face to face encounter by prescriber attached:** ☐ **(Y)** ☐ **(N)**

Name: _____ **MD Medicaid Provider number:** _____

Address: _____

_____

Telephone: (____) _____

Prescriber's Signature: _____

TO BE COMPLETED BY PRESCRIBER: LMN Attached: ☐ **(Y)** ☐ **(N)** **Length of Need:** ____ **(months rental)** ☐ **(lifetime)**

Diagnosis and Present Physical Condition: _____

_____

Medical Justification (be specific): _____

_____

Prognosis: _____

Notes: If appropriate item type block is not checked, form will be returned. DME/DMS **cannot** be on same form. CPAP requests require sleep apnea studies or PFT's.

AUTHORIZATION NUMBER

SUBMIT TO: **Office of Systems Operations & Pharmacy**
Division of Claims Processing
P.O. Box 17058
Baltimore, Maryland 21203

DHMH-4527
Rev 11/2012

COMPLETE REVERSE SIDE