

CHNCT DME REQUEST FORM

Member Name: _____ Date of Birth: _____

Member ID: Diagnosis: _____

Contact Name: _____ Phone: _____

Company Name: _____ Fax: _____

Ordering MD: *(Please clearly print physician's FULL name)* _____

Please note: We cannot process this request if we cannot read the doctor's name.

List requested items: **(Please be sure to include codes)**

Code:	Description:	Purchase/Rental:	Used/New:
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please provide all above information and fax to CHNCT Care Management at 203-265-3994 along with a copy of the script and clinical notes. Thank you!

CPAP – Please provide the following: Sleep study

Renewal - include member compliance or Contact Care Plan

Oxygen – Please provide the following: O2 sats on room air

Clinical notes must be faxed to CHNCT for review
Please fax request to 203-265-3994. Thank You

****PLEASE ALLOW 2 BUSINESS DAYS FROM RECEIPT OF
ALL CLINICAL INFORMATION TO PROCESS REQUEST****