



COMMUNITY  
HEALTH NETWORK  
OF CONNECTICUT, INC.\*

11 Fairfield Boulevard, Wallingford, CT 06492  
(800) 440-5071 Fax (203) 265-3994 www.chnct.org

**CHNCT DME REQUEST FORM**

Member Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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 fill out above information and fax to CHNCT Care Management at 203-265-3994 along with a copy of the script and any other needed information. 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\*\***