MedStar Family Choice

Attn: **CARE MANAGEMENT**
MedStar Family Choice
FAX: (410) 933-2274

PERSONAL AND CONFIDENTIAL

PHYSICIAN NAME: _____
PHYSICIAN ADDRESS: _____
_____
PHYSICIAN NPI: _____
PHONE NUMBER: _____

Authorization request for:
PATIENT: _____
ADDRESS: _____
_____

MFC ID#: _____
DATE OF BIRTH: _____
ICD10 CODE: _____

Date of Service: _____
Date when DME reaches 90 days: _____
OR Current Auth# Expires: _____
Original Set Up: _____

HCPCS Code	Item Description	Quantity/Units
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Comments: _____

Company Name: _____ NPI: _____

Representative Name: _____ Phone Number: _____

Date Request Submitted: _____ Fax Number: _____

Physician signature not required. Request must include current clinical documentation.