

Durable Medical Equipment Referral Worksheet  
Attn: Medical/Surgical Coordinator  
Phone Number 1-800-891-2520  
Fax Number: 567-661-0846

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

Paramount ID# \_\_\_\_\_

DOB: \_\_\_\_\_

Paramount Secondary ID#: \_\_\_\_\_  
(if applicable)

Requesting Physician: \_\_\_\_\_

Contact Person: \_\_\_\_\_

NPI: \_\_\_\_\_

Provider Billing Tax ID (TIN): \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

ICD-10 Code: \_\_\_\_\_

HCPCS Codes: \_\_\_\_\_

Continuation of Care Request (Concurrent Review): Yes: \_\_\_\_\_ No: \_\_\_\_\_.

If yes, please include previous authorization approval number: \_\_\_\_\_

.....

Date Dispensing of Item: \_\_\_\_\_

Company Name Dispensing DME Item: \_\_\_\_\_

NPI #: \_\_\_\_\_ Tax ID#: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Name of Person Completing Form: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

.....

*Please send the following information*

- Brief medical/clinical history
- Current signs and symptoms
- Results of any pertinent diagnostic testing

**\*\*PLEASE NOTE: OHIO BENEFIT ADMINISTRATORS IS NO LONGER ABLE TO REVIEW FOR RETRO DATES OF SERVICE \*\***

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