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 **