Durable Medical Equipment
Repair or Replacement Information

- This form should be completed and included with the General Prior Authorization request form for all DME repair or replacement requests.
- All fields marked with an asterisk (*) are required.

Today's Date: *	
Beneficiary Name: *	Medicaid ID #:*

Information for item(s) that is being repaired or replaced. Enter the initial date of delivery of the most recent date of repair or replacement.

HCPCS Code*	DME Item Description*	Date of Item Delivery/Repair*	Quantity*