SSM Health
Prior Authorization Form
Durable Medical Equipment
Fax completed form to:
314-951-5483

*****Required***Please choose plan:**

- ☐ Exclusive Choice
- ☐ Indemnity
- ☐ Saints Care
- ☐ Smart Care
- ☐ St. Francis
- ☐ St.MarysGoodSamaritan

☐ **Pre-Service Non-Urgent (Physician Signature NOT Required)**

☐ **Pre-Service Administratively Urgent (Physician Signature NOT Required)**
(Services which do not meet the definition of Medically Urgent, however, are deemed to be time sensitive by one of the affected parties.))

☐ **Pre-Service Medically Urgent (Attending Physician Signature REQUIRED Below)**
(Medically Urgent—In the opinion of the attending physician, there is a risk to the member's life, serious bodily injury or pain that cannot otherwise be managed.)
Attending Physician Signature:_____Date:_____

PATIENT DEMOGRAPHICS		
Patient Name:		Date of Birth:
Member ID:		Phone Number:
Street Address:		
City:	State:	Zip Code:

REFERRING PROVIDER INFORMATION		
Provider Name:		Phone #:
Street Address:		Fax #:
City:	State:	Zip Code:
Provider #:	Specialty:	

REFERRED TO PHYSICIAN/FACILITY/PROVIDER INFORMATION		
Referred To:		Phone #
Street Address:		Fax #
City:	State:	Zip Code:
Specialty:		

REQUEST INFORMATION				
Date(s) of Service:	ICD Code(s) and Description:			
CPT Code(s) and Description:				
# of Visits	3rd party liability:	☐ W/C	☐ MVA	☐ Other

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The completed form can be faxed to: (314) 951-5483.
If you have any questions regarding the services or form, please contact SSM Health at 314-989-2355.
Requests to non-plan providers must be approved prior to obtaining services.
Updated: 02/2017

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EQUIPMENT INFORMATION				
Type of Equipment	**HCPCS**	**Quantity**	**Rental (R) or Purchase (P)**	**Price**
Comments/Additional Information				

Form Submitted By:		
Name:	Phone:	Fax:

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