



# BlueCross BlueShield of Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

**Durable Medical Equipment  
Prior Authorization Form**

Please **fax** completed forms to **(816)-502-4910**  
If you have any questions please call (816)395-3989

Prior Authorization is required for selected Durable Medical Equipment (DME). To determine if a particular DME item requires prior authorization, please review the DME List

Patient's Name		BCBSKC ID (NOT SS#)		DOB	
Diagnosis Code(s)		Delivery Date		Physician's Name	
DME Company		Contact Person		Contact Phone # Ext.	

**WHEELCHAIR (ELECTRIC OR SPECIAL SIZE) or SCOOTER** HCPC CODE \_\_\_\_\_  
 \_\_\_ New \_\_\_ Replacement \_\_\_\_\_ Expected Duration of Use  
 Can Patient Maneuver Manual Wheelchair? Yes No (If No, Explain Limitations Below)

**HOSPITAL BED, Specialized** HCPC CODE \_\_\_\_\_  
 \_\_\_ Rental \_\_\_ Purchase (Please Explain Patient's Medical Necessity for the specialized Hospital Bed Below)

**ALTERNATING PRESSURE PAD** HCPC CODE \_\_\_\_\_  
 If patient has decubitous ulcer, what stage is it? \_\_\_\_\_ (Please Explain Patient's Medical Necessity for the Pad Below)

**PROSTHETICS, Including Myoelectric** HCPC CODE \_\_\_\_\_  
 \_\_\_ Initial Prosthetic \_\_\_ Replacement Prosthetic  
 \_\_\_ Traumatic/Surgical Amputee \_\_\_ Congenital Absence of Limb

**Blood Glucose Monitor with Special Features** HCPC CODE \_\_\_\_\_  
 (Please Explain Patient's Medical Necessity for the special features below)

**IMPLANTABLE INFUSION OR INSULIN PUMP** HCPC CODE \_\_\_\_\_  
 (Please Explain Patient's Medical Necessity below)

**COCHLEAR IMPLANT** HCPC CODE \_\_\_\_\_  
 \_\_\_ 18 months of age or older \_\_\_ Attempted Hearing or Vibrotactile aid with little or no benefit  
 \_\_\_ Absence of Cochlear Development \_\_\_ Bilateral Profound Sensorineural Deficits  
 \_\_\_ Deafness d/t Lesion of Acoustic Nerve or Central Auditory Pathway

**OXYGEN SYSTEMS** HCPC CODE \_\_\_\_\_  
 Oxygen Saturation on Room Air: \_\_\_ At Rest \_\_\_ With ADLs \_\_\_ Prescribed FiO<sub>2</sub> \_\_\_ L/Min  
 \_\_\_ Hours Per Day of Use Mask OR Nasal Cannula Is Back Up System Used: Yes No

**ORTHOTIC SEATING SYSTEM** HCPC CODE \_\_\_\_\_  
 (Please explain Patient's Medical Necessity below)

**OTHER** HCPC CODE \_\_\_\_\_  
 (Please explain Patient's Medical Necessity below)

### COMMENTS

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Please allow two (2) business days from date of receipt of all necessary information for determination.  
Duplicate submissions slow the process.

All patient information is strictly confidential.

Incomplete forms will be returned