# HSCSN Order for DME

THE HSC HEALTH CARE SYSTEM
Health Services for Children with Special Needs, Inc.

This form must be completed by a treating practitioner. Fax this form and supporting documents to HSCSN Utilization Management at **Fax: 202-721-7190** or email: **UM@hschealth.org.** Medical records documenting the most recent face-to-face visit should be submitted with each request.

**IMPORTANT TO NOTE: This request will not be processed unless all of the items below are completed.**

| **DATE OF ORDER:** | |
|---|---|
| **PROVIDER** | **MEMBER** |
| **Ordering Provider (MD or NP):** | **Member Name:** |
| **Provider NPI #:** | **Member ID:** **DOB:** |
| **Provider Phone #:**<br>**Fax #:** | **Primary Diagnosis: (Include ICD-10 code)** |
| **Provider Email:** | **Other Diagnoses:** |
| **Description of Requested DME** and **Quantity Requested** | **Duration of use/how long needed:** |
| **STATEMENT OF MEDICAL NECESSITY/JUSTIFICATION** | |
| **CERTIFICATION OF FACE TO FACE VISIT**<br>**I certify that I have had a face to face encounter with the above listed HSCSN enrollee on (date of face to face visit)**<br>**Please Submit Most Recent Clinic Note** | |
| **OPTIONAL - SELECTION OF DME PROVIDER DME PROVIDER**<br>**NAME (IF KNOWN):**<br>**DME PROVIDER PHONE#:** **FAX #:**<br>**DME PROVIDER EMAIL:** | |

Signature of Ordering Provider: _____ Date: _____

Ordering Provider Printed Name: