

SIHO DME AUTHORIZATION REQUEST

Patient Name: _____	Patient ID#: _____
Date: _____	Patient's Date of Birth _____
Physician's Name and phone # (printed): _____	
DME Vendor Name: _____	
DME Vendor Address: _____	

Rental Purchase

Type of Equipment: _____ Cost: _____

History of current condition, date of occurrence, any background information: Include Diagnosis (es)
(Using – ICD9_codes)

Functional Limitation: (Describe in terms of patient's condition.)

Patient Status: (Describe in terms of patient's condition.)

Expected Duration of Use: (Specify the equipment being prescribed and for how long)

**PLEASE PROVIDE A COPY OF THE PRACTITIONER'S
CURRENT ORDER**