



**BlueCross BlueShield
of Tennessee**

P.O. Box 180205
Chattanooga, TN 37402
www.bcbst.com

THIS INFORMATION IS CONFIDENTIAL

**BlueAdvantage
Durable Medical Equipment
Authorization Request Form
Fax Number: 1-800-255-0244**

Member Name: _____ Group Number: _____
 ID Number: _____ Date of Birth: _____
 Address: _____
 Diagnosis: _____ Date Diagnosed: _____
 Prognosis: _____ Date Last Seen: _____ Date of Surgery: _____

Attending Physician: _____
 Address: _____
 Telephone Number: _____ Fax Number: _____

Supplier: _____
 Address: _____
 Telephone Number: _____ Fax Number: _____
 Contact: _____ Start Date: _____ Duration: _____

Equipment prescribed (e-code, narrative and estimated cost)

Special Features

1. _____
2. _____
3. _____
4. _____

Misc. Info.:

Oxygen/Equipment

1. Arterial blood gas results, date drawn: _____
2. PO2 levels: _____
3. Oxygen Saturation: _____
4. Were pulmonary function studies done? If so, please include a copy of results. _____

***Please include a copy of the Certificate of Medical Necessity (CMN) and prescription signed by the attending physician.**