El Paso Health
HEALTH PLANS FOR EL PASOANS. BY EL PASOANS

MEMORANDUM

TO: Valued Durable Medical Equipment (DME) Providers

FROM: El Paso Health

DATE: 02/25/2025

RE: DME/Medical Supplies Request Form

MCO's are no longer required to use the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form. Instead, MCO's may use their own forms, as long as they include all federally required information.

As a result, Providers now have two options to submit a DME Request:
1) the HHS Title XIX DME/Medical Supplies Prescribing Provider Order form
or
2) the El Paso Health DME form (see attached).

Requirements for Option 2 above:
- EPH DME form completed by the DME Provider (no physician signature required on the form)
- Physician order with DME requested (frequency and quantity)
- Clinical supporting the request, when applicable.

EPH will approve an initial DME prior authorization (PA) for a period of up to six months, at which point the DME provider must submit a request to the ordering physician or allowed Practitioner for continuation of services if medically necessary, and seek a new authorization from EPH for a period of up to 12 months.

If you have any questions regarding this communication please contact our Provider Relations team at 915-532-3778 or email us at ProviderRelationsDG@elpasohealth.com.

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DME REQUEST FORM

(REPLACES THE HHS TITLE XIX DME/MEDICAL SUPPLIES PRESCRIBING PROVIDER ORDER FORM)

MEMBER INFORMATION			
Member Name*:		Referral Date:	
Member DOB*:		Phone:	
Address:			
Medicare Number*:		Medicaid Number*:	
STAR Plus Waiver:	☐ Yes ☐ No	☐ Dual ☐ Non-Dual	
Member DX:			

RENDERING DME PROVIDER INFORMATION (Requesting Provider)			
Provider Name*:		Phone:	
Provider Address*:			
Provider Fax Number:			
Tax ID*:		NPI*:	
Taxonomy*:		Benefit Code*:	

Items/Services requested: *Check off items needed on the right to include *quantity (units) and* *Include *HCPCS Code(s) below:* - _____ - _____ - _____ - _____ - _____ - _____ - _____ - _____ - _____ - _____ - _____	☐ Incontinence supplies: Total units_____ ☐ Adult Diapers size: _____ ☐ Pull-on briefs size: _____ ☐ Chux, underpads: _____ ☐ Wipes, barrier cream: _____	☐ Wheelchair (manual standard): _____ ☐ Wheelchair cushion: _____ ☐ Specialty wheelchair (specify):_____ ☐ Power Wheelchair: _____ ☐ Scooter: _____
	☐ Walker (standard): _____ ☐ Walker w/wheels: _____ ☐ Rollator (walker w/wheels & seat): ____ ☐ Mobile Stander: _____	☐ Enterals (specify): _____ ☐ Nutritional Supplements (specify): _____
	☐ Hospital bed: ____ ☐ Air mattress: ____	☐ Blood Pressure Monitor: ____ ☐ Glucometer & Supplies: ____
	☐ Hoyer Lift: ____ ☐ Bath Lift: ____ ☐ Trapeze Bar: ____ ☐ Transfer board: ____	☐ Shower chair: ____ ☐ Bedside commode: ____ ☐ Tub Transfer Bench: ____ ☐ Raised Toilet Seat: ____
	Other services needed (specify):	

REQUESTING PHYSICIAN OR ALLOWED PRACTITIONER INFORMATION (Attach Signed and Dated Physician Order)			
Name*:		NPI*:	
Phone:		Fax:	
Duration of need for DME/Supplies:	_____ month (s)	Date of Services:	From_____ To _____

Note: Medicaid is payor of last resort. Please coordinate benefits as appropriate.

Note: EPH has removed prior auth requirement for Incontinence Supplies unless exceeding allowable limits by TMPPM 2.2.15, Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook.

* Essential/Critical field (information must be entered) or prior authorization will be returned