TRIPLE-S ADVANTAGE

☐ In Patient ☐ Urgent (Expedite)
☐ Ambulatory/Out Patient ☐ Routine (Standard)

Formulary for Request Durable Medical Equipment (DME)

Member Name:	Identification Number:	Date:
☐ Female ☐ Male	Phone Number:	
Address:	Weight: / Height: / Allergies:	
Name of Requesting Physician:	Referral Source:	
	☐ Doctor's Office ☐ Hospital ☐ Skilled Nursing Facility ☐ Nursing Home	
Address:	Phone Number:	Fax Number:
Diagnosis Codes:	Diagnosis:	
Referral to:	Phone Number: Fax Number:	
Discharge Pending: ☐ Yes ☐ No / Facility's Name:	Admission Date: / /	Discharge Date: / /

Home Nutrition: (Include Nutritional Evaluation, Calories and Special Diet)

☐ Nutritional Evaluation ☐ Parenteral Nutrition ☐ Enteral Nutrition ☐ Feeding Machine

Name: Rate: Calories: Intake Method:

DME: (Check Applicable Equipment)

Walker Type:
Wheelchair Type:
Commode:
Bed Type:
Cane/Crutches
Seat Lift:
Lifter:
Grab Bars:
Uro/Ostomy (size):
Others:

CPM/Degrees: _____ Flexion: _____ Extension: _____
Tens/leads: _____ Settings: _____ Frequency: _____
Suction Pump Catheter: _____ Size: _____

Blood Glucose Monitoring

Testing Frequency

Glucometer
Lancets Device
Strips
Lancets
Control Sol.

QD
BID
TID
QID

Diabetic: ☐ Yes ☐ No

Insulin Dependant: ☐ Yes ☐ No

Oxygen

Type: ☐ Gas ☐ Liquid ☐ Other: _____
Via: ☐ Nasal Cannula ☐ Ventury Mask : _____
LPM: _____ / Hours:_____ / Days:_____
Tank Size:____ Quantity: _____ / Concentrator_____
Oximetry: Sat. 0_2 _____% ABG's / PO_2: _____
Length of Need:_____
O_2: Humidifier Conserving Device

_____C-PAP _____ cmH2O _____Bi-PAP _____ Ipap _____ Epap

Treatment Frequency: _____ /Days RR: _____/min
Ramps Setting: _____
Mask Size: _____ Head Gear: _____
Length of Need: _____
O_2 LPM: _____ Humidifier:_____

Include: Sleep study, results/neuromuscular condition that justifies the use of equipment.

Nebulizador Duration 2 month _____

Albuterol 0.083% or 2.5mg/3ml
Frequency: _____

Ipratropium 0.02% or 0.5mg.2.5ml
Frequency: _____

Albuterol 2.5 mg/3ml / Ipratropium 0.5mg
Frequency: _____

Budesonide 0.25mg/2ml or 0.5 mg/2ml
Frequency:_____

Xopenex 0.31/3ml or 0.63mg/3ml or 1.25 mg /3ml
Frequency: _____

Provider Name: (Printed)

Signature/License/NPI Number:

Ventilators (Patient Evaluation Required)

SIMV:_____ CMV: _____
Specify: _____ Tvol: _____
Respiratory Rate: _____ FI02%: _____
Pressure:_____ Peep: _____
Other:_____

Preauthorization Use Only

☐ Approved
☐ Denied

Authorization Number:

Determination Date:

Health Plan Coordinator Name: (Printed)

Platino & Non Platino Members Forms Send To: Clinical Medical Services Fax. 787-622-3449

Rev. 9/2015

Rev. 9/2014