HealthPartners

Wigs

DME Medical Review Form

To be completed by a Health Professional (MD, NP, etc.), not Vendor

Member name:	Date of birth:	Member #:
Completed by:	Phone #:	Fax #:

Ordering practitioner:	NPI #:
Clinic name:	Clinic NPI# or Fed Tax ID#:
Clinic phone #:	Clinic fax #:
Diagnosis:	ICD-9/10:

1. Does member have a diagnosis of alopecia areata, alopecia totalis, or alopecia universalis?
   ☐ Yes ☐ No
2. Does member have hair loss related to another medical or health condition?
   ☐ Yes ☐ No
   Explain:____

Additional Information

I confirm that the information above is correct.
Physician or Treating Practitioner Signature: **Date:**

Please fax this completed form to member's Durable Medical Equipment Vendor.
For questions, call (952) 883-6333
Please include fax cover sheet when submitting.