

SUPPORTING DOCUMENTATION – PRESCRIPTION FOR DURABLE MEDICAL EQUIPMENT CLAIM

Use this form to submit a copy of the prescription required for reprocessing of your durable medical equipment claim.

Note: This form should not be used to submit a corrected claim and documentation, a reconsideration, or formal appeal.

Claim Information

Please provide the information below to help locate your claim:

Provider's Taxpayer Identification Number (TIN):

Provider's National Provider Identifier (NPI):

Sponsor (SSN) (XXX-XX-XXXX):

or DoD Benefits Number (DBN) (XXXXXXXXXX-XX):

Claim Number:

Submit Form and Documentation

Please only submit this form and your supporting documentation. Any other attachments such as claim images, EOBs, or letters will delay reviewing and processing.

Mail or fax this completed form along with your prescription to:

PGBA: TRICARE DME CMN Forms
P.O. Box 202167
Florence, SC 29502

Fax: 877-989-0030 (PGBA)

Note: Please use a separate form for each claim and its supporting documentation. If submitting by fax, please send one request at a time as multiple submissions in the same fax will delay handling and review.