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| Date of Original purchase/Delivery:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Manufacturer: |
| Original Payer:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |               |
| Reason for replacement/repair:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |               |
| <b>CLINICAL INFORMATION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |               |
| <ul style="list-style-type: none"> <li>• Please submit written documentation from the medical record to support the procedure, including photos when applicable. Missing this information may delay the decision on your request or may result in Lack of Information denial.</li> <li>• Documents to attach (where applicable): History and Physical, Therapy Progress Notes, Face-to-face encounter, etc.</li> </ul>                                                                                                                               |               |
| <b>OUT-OF NETWORK SERVICES ONLY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |               |
| <ul style="list-style-type: none"> <li>• Has the service been scheduled already? <input type="checkbox"/>Yes <input type="checkbox"/>No</li> <li>• Is this a specialized service that no other In-network provider can render? <input type="checkbox"/>Yes <input type="checkbox"/>No</li> <li>• Does the member have an established relationship with the provider that should not be interrupted? <input type="checkbox"/>Yes <input type="checkbox"/>No</li> </ul> <p style="margin-left: 40px;">If "Yes", explain (include last visit date):</p> |               |