DURABLE MEDICAL EQUIPMENT ALTERNATE REIMBURSEMENT RATE REQUEST FORM

Instructions: Attach completed Alternate Reimbursement Rate Request Form to submitted claim. For each item review requested, also attach documentation demonstrating that a less expensive product is not available to meet the medical needs of the recipient.

Note: This form may not be used to request higher reimbursement rates for enteral nutrition (B-codes) and incontinence supplies (T-codes) as they are not eligible for higher reimbursement rates beyond those published in the applicable Alaska Medicaid DME fee schedule.

Billing Provider Information	
Provider Name	Provider Alaska Medicaid ID
Provider Address	
Provider Contact Name and Telephone Number	
Member Information	
Member Name *(Last, First, MI)*	Member Alaska Medicaid ID
Claim Information	
Date of Service	
Claim Line # *(up to 3 total)*	Procedure Code(s) for Alternate Rate Request *(up to 3 total and should correspond with claim line)*
_____	_____
_____	_____
_____	_____
Provider Signature	
_____ Signature of Provider	_____ Date