



### DME Authorization

- |   |  |
|---|--|
| <input type="checkbox"/> Specialty bed              | <input type="checkbox"/> Electric/Specialty wheelchair |
| <input type="checkbox"/> Specialty mattress/cushion | <input type="checkbox"/> Oxygen                        |

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_

ID number: \_\_\_\_\_ Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

HCPCS codes: \_\_\_\_\_ DME list price: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Patient's prognosis: \_\_\_\_\_

How progressive is the patient's condition? \_\_\_\_\_

Treatment start date: \_\_\_\_\_ Length of need: \_\_\_\_\_ months \_\_\_\_\_ days \_\_\_\_\_ years

#### Billing provider information

Physician name: \_\_\_\_\_ Tax ID: \_\_\_\_\_

Physical address (no P.O. boxes): \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Contact name: \_\_\_\_\_ Contact phone: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_

#### Attach the following documentation:

- Letter of medical necessity and/or physicians orders
- Documentation of patient's general condition including upper and lower body strength and activity level
- Documentation of patient status (i.e., bed confined, chair confined, ambulatory, orientation, orthopedic impairment, etc.)
- For Oxygen, saturation rate
- Any other additional information pertinent to your request

**Review of this service is pending the completion of this form. Incomplete forms will be returned; attach additional pages as needed. To avoid delay in processing your request, please provide all information requested.**

**IMPORTANT: Please fax completed form and required documents to (816) 257-3515 or (816) 257-3255.**



**Prosthetic device Pre-Authorization Checklist (L5000-L8499)**

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_

ID number: \_\_\_\_\_ Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

State of Residence: \_\_\_\_\_

HCPCS codes: \_\_\_\_\_ DME list price: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Patient's prognosis: \_\_\_\_\_

Co morbid Conditions: \_\_\_\_\_

Functional Level (lower extremity prosthetics only): K- \_\_\_\_\_

Date of amputation: \_\_\_\_\_ Side: \_\_\_\_\_

**Activities of Daily Living** (Please check all that apply)

- Walking    Running    Swimming    Skiing    Hiking    Golf  
 Dancing    Weight training    Aerobics    Racquet sports    Hunting/Fishing

Average ambulation distance per day:    Less than 1 block    1-3 blocks    1/2 mile    1 mile  
 1-2 miles    >2 miles

- Personal hygiene activities (brushing teeth, etc)  
 Household activities (cooking, cleaning, etc)  
 Walk up and down stairs  
 Drive a vehicle  
 Other: \_\_\_\_\_

**Questions: Call Care Management at (800) 220-7898, Ext. 3100.  
Payable benefits are subject to the terms and conditions of the Health Benefit Plan.**



**Prosthetic Notes:**

- Evaluation and related notes from Prosthetist (required)
- Measurements (required for replacement devices)
- Prescription signed by a physician (required)

**If Replacement (i.e. componentry, socket or replacement device):**

Reason for Replacement:

Preparatory to Definitive

- Date Preparatory Device Provided:

Wear and Tear

- Areas and extent of irreparable damage
- Date last prosthesis provided
- History of repairs and adjustments to existing componentry
- Cost of repair will exceed 60% of cost of new prosthesis

Anatomical Change

- Date last prosthesis provided
- Revision Surgery?
- Change in Residual Limb Volume?
  - Before and after measurements required
  - Increase in residual limb volume?
  - Decrease in residual limb volume?
    - Indicate weight loss/gain
    - Indicate current sock supply

**If Replacement Device Versus Replacement Socket:**

Rationale for new device versus replacement socket:-

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Other  
comments: \_\_\_\_\_



**Proposed Componentry:**

HIP:	Manufacturer: Model/Style:
KNEE:	Manufacturer: Model/Style
ANKLE:	Manufacturer: Model/Style
FOOT:	Manufacturer: Model/Style
SHOULDER:	Manufacturer: Model/Style
ELBOW:	Manufacturer: Model/Style
WRIST:	Manufacturer: Model/Style
TERMINAL_DEVICE:	Manufacturer: Model/Style
VASS:	Manufacturer: Model/Style
OTHER:	Manufacturer: Model/Style

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**Billing provider information**

Physician name: \_\_\_\_\_ Tax ID: \_\_\_\_\_

Physical address (no P.O. boxes): \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Contact name: \_\_\_\_\_ Contact phone: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_

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PCIP Header

Spinal Surgery Authorization

Patient Name: \_\_\_\_\_ Date of Request: \_\_\_\_\_

ID: \_\_\_\_\_ DOB: \_\_\_\_\_

DX: \_\_\_\_\_ ICD Code: \_\_\_\_\_

Physician: \_\_\_\_\_ Tax ID: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Facility: \_\_\_\_\_ Tax ID: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

**Surgery information:**

Choose one: Inpatient \_\_\_\_\_ Outpatient \_\_\_\_\_

Date of surgery: \_\_\_\_\_ Surgical levels: \_\_\_\_\_

Will this surgery include artificial disc? Yes  No  Unknown   
Fusion enhancement products (i.e. BMP)? Yes  No  Unknown   
Hardware/implantables (i.e. cages, spacers)? Yes  No  Unknown   
If yes, describe device name, brand, and model number (if known): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*Any implants submitted within a claim for pain management services yet not prior authorized will be subject to review for medical necessity upon GEHA's receipt of the claim.**

PCIP Header

CPT codes: Circle all that apply

22100	22532	22819	63012	63102
22101	22533	22830	63015	63103
22102	22534	22840	63016	63295
22103	22548	22841	63017	63300
22110	22551	22842	63035	63301
22112	22552	22843	63042	63302
22114	22554	22844	63043	63303
22116	22556	22845	63044	63304
22206	22558	22846	63047	63305
22207	22585	22847	63048	63306
22208	22586	22848	63050	63307
22210	22590	22849	63051	63308
22212	22595	22850	63057	63700
22214	22600	22851	63066	63702
22216	22610	22852	63075	63704
22220	22612	22855	63076	
22222	22614	22856	63078	0092T
22224	22630	22857	63081	0095T
22226	22632	22861	63082	0098T
22318	22633	22862	63085	0195T
22319	22634	22864	63086	0196T
22325	22800	22864	63087	0274T
22326	22802	22865	63088	0275T
22327	22804	22899	63090	
22328	22808		63091	
	22810		63101	
	22812			
	22818			

Other CPT codes not listed: \_\_\_\_\_

**IMPORTANT: Submit letter of medical necessity, office notes and diagnostic tests (x-ray, MRI, CT, etc...). Fax completed form and supporting documents to OrthoNet, (877) 304-4409.**

Questions: Call OrthoNet at (877) 304- 4419.

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