



**Utilization Management**  
Phone No.: 1-877-284-0102 Fax No.: 1-800-510-2162

**HealthLink Durable Medical Equipment—Myoelectric prosthetic Pre-Review**

Date: \_\_\_\_\_ Notification # \_\_\_\_\_ (provided after initial review)  
*A Utilization Management representative will fax you a notification number by the next business day after receiving this completed form. This notification number does not indicate an approval or denial of benefits, but only proof that the Plan has been notified. This information will be forwarded to the Plan's Managed Care department. If you have any questions, please call Healthlink at 1-877-284-0102.*

**Provider Information**

Provider's Name: \_\_\_\_\_  
Address \_\_\_\_\_  
Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

**Patient Information**

Patient's Name \_\_\_\_\_  
ID Number \_\_\_\_\_ Patient's DOB: \_\_\_\_\_  
Address \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Daytime Phone No. \_\_\_\_\_

**Ordering Physician Information**

Physician's Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone No. \_\_\_\_\_ Fax No. (Required) \_\_\_\_\_  
TIN: \_\_\_\_\_

**Treatment Information**

Diagnosis & Past Medical History (please include previous treatments and dates): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of injury and/or surgery: \_\_\_\_\_

**The use of myoelectric upper extremity prosthetic devices is considered medically necessary when all of the following criteria have been met:**

1. Does the individual have sufficient neurological, myocutaneous and cognitive function to operate the prosthesis effectively  YES  NO
2. Does the individual have an amputation or missing limb at the wrist or above (i.e., forearm, elbow, etc)  YES  NO
3. The individual is free of comorbidities that could interfere with maintaining function of the prostheses (i.e., neuromuscular disease, etc)  YES  NO
4. Does the individual have sufficient microvolt threshold in the residual limb to allow proper function of the prostheses  YES  NO
5. Can standard body powered prosthetic devices be used  YES  NO
6. Are standard body powered prosthetic devices insufficient to meet the functional needs of the individual in performing activities of daily living  YES  NO
7. Does the individual function in an environment that would inhibit function of the prosthesis (i.e., a wet environment or a situation involving electrical discharges that would affect the prosthesis)  YES  NO

**PLEASE PROVIDE ANY ADDITIONAL CLINICAL INFORMATION YOU MAY HAVE.**

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\* Type(s) of Medical Equipment with HCPC code and prices:

TYPE \_\_\_\_\_ HCPCs \_\_\_\_\_

**Contact Information**

Contact Person \_\_\_\_\_

Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

Staff Signature/Title: \_\_\_\_\_ Date: \_\_\_\_\_

*\*Preferred provider available for DME and HI services*

Benefits depend upon the eligibility of the patient at the time of admission, subject to all other Plan limitations, pre-admission review requirement and prior related claims. Verification of eligibility and description of benefits are based upon the information we have on file and does not guarantee payment.