



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

HealthLink Durable Medical Equipment—Lower Limb 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.

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:

Functional Level: 0 1 2 3 4

Is prosthesis prescribed by physician YES NO

The member will reach or maintain a defined functional state within a reasonable period of time YES NO

The member needs prosthesis for ambulation YES NO

The member's rehabilitation potential is based on functional levels as outlined above YES NO

Ambulating distance

Prosthetic requested:

- Ankle Knee Fluid Pneumatic Other Socket Test Diagnostic Replacement

Socket Replacements:

Are there changes in the residual limb YES NO
Are there functional need changes YES NO
Is there irreparable damage YES NO

Is there wear/tear due to excessive member weight or prosthetic demands of very active amputees  YES  NO

Feet – Specify External keel SACH foot or single axis ankle/foot \_\_\_\_\_

Specify Flexible-keel foot or multi-axial ankle/foot \_\_\_\_\_

A flex foot system, energy storing foot, multi-axial ankle/foot, dynamic response, or flex-walk system or equal, or shank foot system with vertical loading pylon (please describe)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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**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.