Utilization Management
Phone: 1-877-284-0102 Fax: 1-800-510-2162

Durable Medical Equipment – Lower Limb Prosthetic Precertification Review

Date: _____ Reference #: _____(provided after initial review)
A Utilization Management representative will fax you a reference number by the next business day after receiving this completed form. This reference 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 Name: _____

Address: _____

Phone: _____

Fax: _____

Patient Information

Patient Name: _____

ID Number: _____

Patient DOB: _____

Address: _____

Phone: _____

Ordering Physician Information

Physician Name: _____

Address: _____

Phone: _____

Fax: _____

TIN: _____

Treatment Information

Pertinent Medical History (submit history, physical and include previous treatments and dates): _____

_____

_____

Primary Diagnosis: _____

Diagnosis (ICD-10) Code: _____

Primary Procedure: _____

Procedure (ICD-10) Code: _____

Date and type of injury: _____

Date and type of surgery: _____

Functional Level: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Level 0: *Does not have the ability or potential to ambulate or transfer safely with or without assistance and prosthesis does not enhance their quality of life or mobility.*

Level 1: *Has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.*

Level 2: *Has the ability or potential for ambulation with the ability to traverse low-level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.*

Level 3: *Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.*

Level 4: *Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.*

Is prosthesis prescribed by physician? ☐ YES ☐ NO

Will the patient reach or maintain a defined functional state within a reasonable period of time? ☐ YES ☐ NO

Will the patient need prosthesis for ambulation? ☐ YES ☐ NO

If yes, please supply the ambulating distance: _____

Is the patient's rehabilitation potential based on functional levels as outlined above? ☐ YES ☐ NO

Prosthetic Requested

☐ Ankle	☐ Knee	☐ Socket
	☐ Fluid	☐ Test Diagnostic
	☐ Pneumatic	☐ Replacement
	☐ Other _____	☐ Other, specify _____

If Socket Replacements Requested:

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

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): _____

_____

_____

_____

_____

_____

Please provide any additional clinical information

_____

_____

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

Type of Requested Prosthesis: _____

HCPC/CPT Codes: _____

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.

Provider Contact Information

Contact Person: _____

Title: _____

Phone: _____

Fax: _____