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

Durable Medical Equipment – Myoelectric 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): _____

_____

_____

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

_____

_____

_____

_____

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

TYPE: _____ HCPC/CPT: _____

**Preferred provider available for DME and Home Infusion services*

Provider Contact Information

Contact Person: _____

Title: _____

Phone: _____

Fax: _____