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

Durable Medical Equipment – Bone Stimulator 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) __________________

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Date of Injury and/or Surgery: ____

Is the stimulator for spinal fusion? ☐ YES ☐ NO

If yes:

One or more previously failed spinal fusion(s) ☐ YES ☐ NO

Grade III or worse spondylolisthesis ☐ YES ☐ NO

Fusion to be performed at more than one level ☐ YES ☐ NO

History of tobacco use ☐ YES ☐ NO

History of alcoholism ☐ YES ☐ NO

Metabolic diseases where bone healing is likely to be compromised or growth is poor ☐ YES ☐ NO

Diabetes ☐ YES ☐ NO

Renal disease ☐ YES ☐ NO

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.

Other, please specify: ______________________

Is patient's body mass index (BMI) greater than 30? ☐ YES ☐ NO

Is patient 50% over their ideal body weight? ☐ YES ☐ NO

Is the stimulator for a failed spinal fusion? ☐ YES ☐ NO

If **yes,** provide clinical regarding failed spinal fusion:

Date of fracture: ___________________

Date of prior surgery: _______________

Is fracture gap less than one centimeter (1cm)? ☐ YES ☐ NO

Results of serial radiographs or imaging studies where there is no evidence or progression of healing: ____________

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Is the bone growth stimulator a treatment for fracture non-unions and congenital pseudoarthroses of all long and short bones of the appendicular system? ☐ YES ☐ NO

Note: The diagnosis of fracture nonunion must meet **all** of the following criteria:

At least 45 days have passed since the date of fracture or the date of surgical treatment of the fracture?

☐ YES ☐ NO

Serial radiographs or appropriate imaging studies confirm that no progressive signs of healing have occurred?

☐ YES ☐ NO

The fracture gap is less than 1 centimeter?

☐ YES ☐ NO

Is the bone growth stimulator for the treatment of joint fusion secondary to failed arthrodesis of the ankle or knee?

☐ YES ☐ NO

Please provide any additional clinical information

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Provider Contact Information

Contact Person: ____

Title: ________________________________

Phone: ______________________________

Fax: _________________________________

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