



The Benefits of Better Health

Prosthetic Device Authorization (L5000-L8499)

GEHA will notify you of our determination after reviewing the following information:

Date of request: _____

Patient name: _____ Patient phone: _____

ID number: _____ DOB: _____

Member address: _____

Gender: _____ Height: _____ Weight: _____

Billing provider information

Physician name: _____ Tax ID: _____

Address: _____

(no P.O. boxes) City: _____ State: _____ ZIP: _____

Contact: _____

Phone: _____ Fax: _____

Prescribing physician: _____ NPI: _____

HCPCS codes: _____ DME list price: _____

Diagnosis: _____ Patient's prognosis: _____

Co-morbid conditions: _____

Functional level (lower extremity prosthetics only): K- _____

Date of amputation: _____ Side: _____

Activities of daily living (please check all that apply)

- Aerobics Dancing Golf Hiking Hunting/fishing Racquet sports
- Running Skiing Swimming Walking Weight training

Average ambulation distance per day:

- < 1 block 1-3 blocks 1/2 mile 1 mile 1-2 miles > 2 miles

- Personal hygiene activities (brushing teeth, etc.)
- Household activities (cooking, cleaning, etc.)
- Walk up and down stairs
- Drive a vehicle
- Other: _____

Questions: Call Care Management at 800.821.6136, ext. 3100.
Payable benefits are subject to the terms and conditions of the Health Benefit Plan.

Prosthetic notes

- Evaluation and related notes from prosthetist (required)
- Measurements (required for replacement devices)
- Prescription signed by a physician (required)

If replacement (i.e., componentry, socket or replacement device) ...

Reason for replacement: _____

- Preparatory to definitive
 Date preparatory device provided: _____
- Wear and tear
 - Areas and extent of irreparable damage: _____
 - Date last prosthesis provided: _____
 - History of repairs and adjustments to existing componentry: _____

 - Cost of repair will exceed 60% of cost of new prosthesis
- Anatomical change
 - Date last prosthesis provided: _____
 - Revision surgery?
 - Change in residual limb volume?
 - Before and after measurements (required): _____
 - Increase in residual limb volume?
 - Decrease in residual limb volume?
 - Indicate weight loss/gain: _____
 - Indicate current sock supply: _____

If replacement device *versus* replacement socket ...

Rationale for new device verses replacement socket: _____

Other comments: _____

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Proposed componentry

Hip	Manufacturer: _____
	Model/style: _____

Knee	Manufacturer: _____
	Model/style: _____

Ankle	Manufacturer: _____
	Model/style: _____

Foot	Manufacturer: _____
	Model/style: _____

Shoulder	Manufacturer: _____
	Model/style: _____

Elbow	Manufacturer: _____
	Model/style: _____

Wrist	Manufacturer: _____
	Model/style: _____

Terminal device	Manufacturer: _____
	Model/style: _____

Vass	Manufacturer: _____
	Model/style: _____

Other:	Manufacturer: _____
_____	Model/style: _____

Review of this service is pending the completion of this form. Incomplete forms will be returned; attach additional pages as needed. To avoid delay in processing your request, please provide all information requested.

IMPORTANT: Please fax completed form and required documents to 816.257.3515 or 816.257.3255.

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