Arthroplasty Authorization Form

Refer to the back of the patient's ID card under the heading Prior Authorization for the appropriate contact information.

Purpose of this form
You can use this form to initiate your precertification request. The form will also help you know what supporting documentation is needed for GEHA to review your request.

You can find our coverage policies at **Provider resources**. These will allow you to see the criteria used to determine medical necessity and procedures that are not allowable.

For us to review your request properly and to avoid delay, you must complete all sections of the form and provide the necessary supporting documentation. If you have questions about the form or need assistance, you can speak with a surgical specialist at 800.821.6136, ext. 3100.

After you have completed the form
Preauthorization reviews are completed within 15 days from the time that we receive complete information. Please allow for this time when scheduling the procedure. We are not able to consider a request "urgent" unless waiting the regular time limit for authorization could seriously jeopardize a patient's life, health or ability to regain maximum function. Post-service reviews are completed within 30 days.

Arthroplasty Authorization Form

Refer to the back of the patient's ID card under the heading Prior Authorization for the appropriate contact information.

Date of request: ____________________ Anticipated date of service: ______________

Patient name: ___________________________ Phone: ___________________________

Preferred pronouns: _____________________ (optional)

ID number: ___________________________ Date of birth: ____________________

Member address: ____

____

DX: ___________________________ ICD-10 code: ____________________

Physician: ____

Tax ID: ___________________________

Address: ____

____

Contact: ____

Phone: ___________________________ Fax: ___________________________

Facility: ____

Tax ID: ___________________________

Address: ____

____

The clinical information below is mandatory to evaluate medical necessity and should be completed by physician or other clinical staff.

Place of service: ☐ Inpatient ☐ Outpatient

Type of request: ☐ Pre-service ☐ Post-service

Applicable area: ☐ Hip ☐ Knee ☐ Shoulder ☐ Elbow ☐ Other: ________________

Previous surgeries completed to applicable area: _____________________ Date: _____________

Primary diagnosis ICD-10: _______________ ICD-10 codes: ___________ _________ _________

List applicable CPT codes ____

____

Important information regarding Turn Around Time

*Our reviews are completed within **15 days** from the time that we receive complete information. Please allow for this time when scheduling the procedure. We are not able to consider a request "urgent" unless waiting the regular time limit for authorization could seriously jeopardize a patient's life, health or ability to regain maximum function.

IMPORTANT: In addition to this form, submit (1) a complete history and physical (2) an applicable current/complete clinical note that is legible to include tried and failed conservative measures with pain scale and details of functional disabilities, (3) a procedure report [if this is a post-procedure request] and (4) all pertinent test results.

Fax completed form and supporting documents to GEHA at 816.257.3515 or 816.257.3255, or email caremanagementsurgery@geha.com.

Any additional procedure submitted within a claim for surgical services not prior authorized will be subject to review for medical necessity upon GEHA's receipt of the claim. Please include an op report, letter of medical necessity, office notes and diagnostic test (X-ray, MRI, CT, etc.). Fax completed form and supporting documents to GEHA at **816.257.3515** or **816.257.3255**, or email **caremanagementsurgery@geha.com**.

Questions: Call GEHA at 800.821.6136, ext. 3100

Payable benefits are subject to the terms and conditions of the Health Benefit Plan.