



Osteochondral Authorization

(including Grafting and Autologous Cultured Chondrocyte Implantation)

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.

How to complete the form

We recommend reviewing [GEHA's coverage policy for Osteochondral Grafting of Articular Lesions](#) and [GEHA's coverage policy for Autologous Chondrocyte Transplantation](#) before completing this form. 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 help, you can speak with a surgical specialist at 800.821.6136, ext. 3100.

After you have completed the form

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.



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Date of request: _____ Anticipated service date: _____
 Patient name: _____ Phone: _____
 Preferred pronouns: _____ (optional)
 ID number: _____ Date of birth: _____
 Member address: _____

Physician: _____
 Tax ID: _____
 Address: _____

 Contact: _____
 Phone: _____ Ext. _____ Fax: _____
 DX: _____ ICD-10 code: _____

List all proposed CPT/procedure codes: _____

Please specify for each code if Bilateral or Single: _____

IMPORTANT: In addition to this form, submit:

- Current history and physical including height and weight
- Results of Arthroscopic assessment or MRI
- Documentation of conservative treatment and results of conservative treatment
- Any other such documentation to provide evidence that member meets the coverage criteria set forth in the Osteochondral or Autologous Cultured Chondrocyte Implantation coverage policies posted at GEHA.com

Submit completed form and supporting documents to:

GEHA Fax: .816.257.3255 or
 P.O. Box 21542 Color photos to secure email:
 Eagan MN 55121 caremanagementsurgery@geha.com

Questions: Call GEHA at 800.821.6136, ext. 3100

All benefit payments are subject to review for any applicable deductibles, coinsurance, maximums, medical necessity and patient eligibility on the date that the service is provided, or the supply delivered.