GEHA®

Prosthetic Device Authorization (L5000-L8499)

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 help, 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.

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Please note: This form must be completed in full. Authorization requests will not be processed without required information, including supporting documentation.

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

Date of request: _____ Patient phone: _____

Patient name: _____ DOB: _____

Preferred pronouns: _____ (optional)

ID number: _____ State of residence: _____

Gender: _____ Height: _____ Weight: _____

Member address: _____

_____

Billing provider information

Physician name: _____ Tax ID: _____

Physical address: _____

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

Contact name: _____

Contact phone: _____ Ext: _____ Fax: _____

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: _____

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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.

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