Wound Care Authorization

(Negative-pressure wound therapy, Skin substitutes, Other)

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 Negative Pressure Wound Therapy** and **GEHA's coverage policy for Skin Substitutes** 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 assistance, 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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☐ Skin substitute products ☐ NPWT ☐ Other

Date of request: _____ Anticipated service date: _____

Patient name: _____ Phone: _____

Preferred Pronouns are: _____ (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 if bilateral or single: _____

_____

Total number of skin substitute products units requested: _____

Name of skin substitute product: _____

Total number of applications requested: _____

How progressive is the patient's condition? _____

Treatment start date: _____

Length of need: _____ months, _____ days, _____ years

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IMPORTANT: In addition to this form, submit:

- Detailed history of tried and failed wound treatments chronologically comparable over 4-6 weeks prior to requested therapy, and off-loading status.
- Recent history and physical including physical impairments and activity status, recent albumin/pre-albumin reports, HbA1c in the last 90 days for diabetics, dietary assessment, and care management plan for patients with diabetes or compromised nutrition status.
- Detailed wound bed description and weekly wound measurements that are chronologically comparable over time.
- Vascular studies for lower extremity wounds.
- For wounds with a history or signs/symptoms of infection include consults with specialties including infectious disease, updated lab including: Wound Cultures, Sedimentation Rate, CRP, and plan of care to treat the infection.
- Any other additional information pertinent to your request.

Submit completed form and supporting documents to:

GEHA
P.O. Box 21542
Eagan MN 55121

Fax: 816.257.3255 or to
Secure email:
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.