



WOUND CARE PRIOR AUTHORIZATION FORM

Submit this completed form by fax to **1-833-610-2399**, or on our provider portal:
<https://secure.healthx.com/ProCareAdvantage.Provider>
 Call 1-844-206-3719 (TTY 711) to speak with a representative.

Members must be referred to in-network facilities and providers unless it is an emergency, other exclusions may apply. Authorized services are not a guarantee of payment. Payment is only authorized for medical services noted below and is subject to the limitations and exclusions as outlined in the Member Handbook/ Certification of Coverage. All requests are reviewed for medical necessity. Incomplete submissions may result in processing delays. Information must be legible.

Routine/Standard Serious jeopardy to the member's life or health or ability to regain maximum function

MEMBER INFORMATION			
Member Name:	Member ID:		
Date of Birth:	Member Residence:		
REQUESTING PROVIDER/FACILITY			
Requestor's Name (Print):	Phone Number:	Fax Number:	Date of Request:
Referring Provider (If other than requestor):	Referring Provider: <input type="checkbox"/> NP/PA <input type="checkbox"/> PCP <input type="checkbox"/> Therapy Rep <input type="checkbox"/> Other		
SERVICING PROVIDER/FACILITY			
Servicing Provider Name:			
NPI/ TIN Number:	Phone Number:	Fax number:	
Address:			
City:	State:	Zip:	
SERVICE TYPE REQUESTED			
<input type="checkbox"/> Initial request <input type="checkbox"/> Extension of services, Authorization #:			
Current Diagnoses and ICD-10 Code(s):			
Type of Wound Therapy being requested: <i>If request is for skin grafting please specify number of applications and units being requested.</i>			
Service:	CPT/HCPCS code:	Site:	Location:
			<input type="checkbox"/> Bilateral <input type="checkbox"/> Left <input type="checkbox"/> Right
			<input type="checkbox"/> Bilateral <input type="checkbox"/> Left <input type="checkbox"/> Right
			<input type="checkbox"/> Bilateral <input type="checkbox"/> Left <input type="checkbox"/> Right
			<input type="checkbox"/> Bilateral <input type="checkbox"/> Left <input type="checkbox"/> Right
			<input type="checkbox"/> Bilateral <input type="checkbox"/> Left <input type="checkbox"/> Right



Negative Pressure Wound Therapy (NPWT): <input type="checkbox"/> N/A <input type="checkbox"/> Disposable/Mechanical NPWT <input type="checkbox"/> Electrical NPWT Pump <input type="checkbox"/> Single Use NPWT Device Brand/Name of Device: _____	
Profile Wound #: _____ Location: _____ <input type="checkbox"/> Bilateral <input type="checkbox"/> Left <input type="checkbox"/> Right How long has the wound been present? Drainage: <input type="checkbox"/> None <input type="checkbox"/> Scant <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy/Copious Type: <input type="checkbox"/> Burn <input type="checkbox"/> Diabetic Foot Ulcer <input type="checkbox"/> Traumatic <input type="checkbox"/> Venous Stasis Ulcer <input type="checkbox"/> Other: _____ Wound Thickness: <input type="checkbox"/> Deep <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Superficial Previous treatment: _____ Initial Measurements (cm) Date: _____ Length: _____ width: _____ depth: _____ cm ² : _____ Tunneling: _____ Undermining: _____ Current Measurements (cm) Date: _____ Length: _____ width: _____ depth: _____ cm ² : _____ Tunneling: _____ Undermining: _____	
Profile Wound #: _____ Location: _____ <input type="checkbox"/> Bilateral <input type="checkbox"/> Left <input type="checkbox"/> Right How long has the wound been present? Drainage: <input type="checkbox"/> None <input type="checkbox"/> Scant <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy/Copious Type: <input type="checkbox"/> Burn <input type="checkbox"/> Diabetic Foot Ulcer <input type="checkbox"/> Traumatic <input type="checkbox"/> Venous Stasis Ulcer <input type="checkbox"/> Other: _____ Wound Thickness: <input type="checkbox"/> Deep <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Superficial Previous treatment: _____ Initial Measurements (cm) Date: _____ Length: _____ width: _____ depth: _____ cm ² : _____ Tunneling: _____ Undermining: _____ Current Measurements (cm) Date: _____ Length: _____ width: _____ depth: _____ cm ² : _____ Tunneling: _____ Undermining: _____	
Additional Comments: _____	
CLINICAL INFORMATION	
<ul style="list-style-type: none"> Please submit written documentation from the medical record to support the procedure, including photos when applicable. Missing this information may delay the decision on your request or may result in Lack of Information denial. Documents to attach (where applicable): History and Physical, Therapy Progress Notes, Face-to-face encounter, etc. 	
OUT-OF NETWORK SERVICES ONLY	
<ul style="list-style-type: none"> Has the service been scheduled already? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this a specialized service that no other In-network provider can render? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the member have an established relationship with the provider that should not be interrupted? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", explain (include last visit date): _____ 	