HealthPartners®

Prior Authorization for Continuous Passive Motion (CPM) Device

DME Medical Review Form

Call Utilization Management (UM) at **(952)883-6333** with questions. Incomplete forms will be returned. **Submit clinical documentation** to support your request. Sign in at healthpartners.com/provider and use the Authorizations and referrals link to check the status of your prior authorization request.

Member information

First name _____ MI _____ Last name _____

HealthPartners ID # _____ DOB _____

Requester information

Form completed by: first name _____ Last name _____

Your business name _____

Your business street address _____

Your business city _____ Your business state _____ Your business zip _____

Phone* _____ Fax** _____

Ordering physician information

Physician first name _____ Physician last name _____

Specialty _____ NPI _____

Clinic name _____

Clinic street address _____

Clinic city _____ Clinic state _____ Clinic zip _____

Clinic tax ID (claim may be rejected if incorrect) _____

Email _____ Phone* _____ Fax** _____

Vendor information

Vendor name _____

Vendor street address _____

Vendor city _____ Vendor state _____ Vendor zip _____

Billing tax ID (claim may be rejected if incorrect) _____

Phone* _____ Fax** _____

Durable medical equipment

Primary diagnosis code _____ Description _____

Secondary diagnosis code _____ Description _____

Has requested item been provided to member? ☐ Yes ☐ No

If yes, please provide date _____ If no, please provide estimated start date _____

**Confidential voicemail required*
***For outcome notification*

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Will waiting the standard review time seriously jeopardize member's health, life, or ability to regain maximum functioning? ☐ Yes ☐ No

Clinical reason for urgency (not scheduling issues) _____

Request information:

Item(s) Description	HCPC	Modifier	Cost	Start Date	End Date	Unit(s)
		Please select modifier:				
		Please select modifier:				
		Please select modifier:				
		Please select modifier:				
		Please select modifier:				
		Please select modifier:				
		Please select modifier:				

Note: Requests for prior authorization which are not submitted within 30 days of the date item was dispensed could be subject to denial (vendor liability)

HomeLink Contracted Vendors: send this form to HomeLink
Telephone: (866)211-1995
Fax: (855)348-9970

If not contracted with HomeLink: send this form directly to HealthPartners
Telephone: (952)883-6333
Fax: (952)853-8714

1. Has there been recent surgery? ☐ Yes ☐ No

2. Name of Procedure _____ Date of Procedure _____

3. Is the member currently receiving physical therapy in combination with the use of CPM? ☐ Yes ☐ No

   •If yes, is the member receiving active muscle conditioning during therapy? ☐ Yes ☐ No

   •If no, please explain why _____
   clinical documentation from physical therapy and/or the physician must be submitted to support any contraindication

4. Length of need: ☐ 42 Days ☐ Other: _____

5. If requested beyond 42 days, has member had one of the following procedures? Please check all that apply:

   ☐ Joint manipulation Date _____

   ☐ Additional surgery Procedure _____ Date _____

   ☐ Autologous Chondrocyte Implantation (ACI) Date _____

Additional information _____