HealthPartners®

Prior Authorization for Airway Clearance System/Chest Compression Generator System

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: _____

**Confidential voicemail required*

***For outcome notification*

HealthPartners®

Request Information:

Item(s) Description	HCPC	Modifier	Cost	Start Date	End Date
		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. What is the member's diagnosis related to the need for this device?

- ☐ Cystic Fibrosis
- ☐ Immotile Cilia Syndrome
- ☐ Chronic Bronchiectasis confirmed by radiological scan
  - x Type of radiological scan and date _____
  - x Daily productive cough for at least 6 continuous months ☐ Yes ☐ No
  - x Two or more exacerbations in 2 months requiring antibiotic treatment ☐ Yes ☐ No
- ☐ Other Severe Lung Disease. Please Indicate: _____
- ☐ Neuromuscular Disease. Please Indicate: _____
- ☐ Other Medical Condition. Please Indicate: _____

2. Has the member received optimal medical management? (e.g. antibiotics, bronchodilators, and other techniques to enhance mucous clearance such as use of a flutter valve and/or chest physiotherapy?

☐ Yes ☐ No Explain: _____

_____

3. Have standard treatments failed to help the member mobilize secretions or cannot be performed?

☐ Yes ☐ No Explain: _____

_____

4. If this is for ongoing rental, please answer the following:
   - x Has the patient been using the device consistently? ☐ Yes ☐ No
   - x Has the device been effectively managing the member's condition? ☐ Yes ☐ No

Additional Information: _____

_____

_____

I confirm that the information above is correct.

Physician or Treating Practitioner Signature: _____ **Date:** _____