HealthPartners®

Prior Authorization for Pneumatic Compression 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: _____

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

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

***For Commercial members, Pneumatic compression devices will be covered for an initial rental period when coverage criteria are met**

Lymphedema Treatment:

1. Is the member under the care of a lymphedema specialist or program? ☐ Yes ☐ No

2. Has the member undergone a FOUR week trial of conservative therapy? ☐ Yes ☐ No If yes, check all that apply:
   ☐ A compression bandage system or compression garment ☐ Exercise ☐ Elevation of the limb
   ☐ Other _____

3. Has the treating physician documented no significant improvement after a trial of conservative therapy?
   ☐ Yes ☐ No *Clinical Documentation Required*

4. Does the member have clinical circumstances that prevent effective pneumatic compression treatment using a device without calibrated pressure (E0650, E0651)? ☐ Yes ☐ No *Clinical Documentation Required*

For segmented or non-segmented pneumatic compression devices with calibrated gradient pressure (E0652):
The member MUST have a 4 week trial using a pneumatic compression device without calibrated gradient pressure (E0650, E0651). This MUST be documented along with medical indications for ordering a device w/ calibrated gradient pressure.
* Attach Documentation

Chronic venous insufficiency (CVI) Treatment:

1. Does the member have one or more venous stasis ulcer(s)? ☐ Yes ☐ No
   If yes, please describe: _____

2. Has the member undergone a trial of conservative therapy for at least 6 months? ☐ Yes ☐ No If yes, check all that apply:
   ☐ A compression bandage system of compression garment ☐ Exercise ☐ Appropriate wound dressings
   ☐ Elevation of the limb ☐ Other _____

3. Has 6 months of conservative therapy failed to heal the ulcer (s)? ☐ Yes ☐ No

4. Does the member have extensive scaring? ☐ Yes ☐ No

5. Contractures? ☐ Yes ☐ No Other: _____

For segmented or non-segmented pneumatic compression devices with calibrated gradient pressure (E0652):
The member MUST have a 4 week trial using a pneumatic compression device without calibrated gradient pressure (E0650, E0651). This MUST be documented along with medical indications for ordering a device w/ calibrated gradient pressure.
*Attach Documentation

Deep vein thrombosis (DVT) prevention:

1. Does member have a contraindication to the use of anti-coagulation medication? ☐ Yes ☐ No
If yes, please describe: _____

Additional Information: _____

_____

_____

I confirm that the information above is correct.

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