Prosthetic Device Authorization (L5000-L8499)

GEHA will notify you of our determination after reviewing the following information:

Date of request: _____

Patient name: _____ Patient phone: _____

ID number: _____ DOB: _____

Member address: _____

_____

Gender: _____ Height: _____ Weight: _____

Billing provider information

Physician name: _____ Tax ID: _____

Address: _____

(no P.O. boxes) City: _____ State: _____ ZIP: _____

Contact: _____

Phone: _____ Fax: _____

Prescribing physician: _____ NPI: _____

HCPCS codes: _____ DME list price: _____

Diagnosis: _____ Patient's prognosis: _____

Co-morbid conditions: _____

Functional level (lower extremity prosthetics only): K-_____

Date of amputation: _____ Side: _____

Activities of daily living (please check all that apply)

☐ Aerobics ☐ Dancing ☐ Golf ☐ Hiking ☐ Hunting/fishing ☐ Racquet sports
☐ Running ☐ Skiing ☐ Swimming ☐ Walking ☐ Weight training

Average ambulation distance per day:

☐ < 1 block ☐ 1-3 blocks ☐ 1/2 mile ☐ 1 mile ☐ 1-2 miles ☐ > 2 miles

☐ Personal hygiene activities (brushing teeth, etc.)
☐ Household activities (cooking, cleaning, etc.)
☐ Walk up and down stairs
☐ Drive a vehicle
☐ Other: _____

Questions: Call Care Management at 800.821.6136, ext. 3100.
Payable benefits are subject to the terms and conditions of the Health Benefit Plan.

Prosthetic notes

- ☐ Evaluation and related notes from prosthetist (required)
- ☐ Measurements (required for replacement devices)
- ☐ Prescription signed by a physician (required)

If replacement (i.e., componentry, socket or replacement device) ...

Reason for replacement: _____

☐ Preparatory to definitive
Date preparatory device provided: _____

☐ Wear and tear

- ☐ Areas and extent of irreparable damage: _____
- ☐ Date last prosthesis provided: _____
- ☐ History of repairs and adjustments to existing componentry: _____

_____

- ☐ Cost of repair will exceed 60% of cost of new prosthesis

☐ Anatomical change

- ☐ Date last prosthesis provided: _____
- ☐ Revision surgery?
- ☐ Change in residual limb volume?
  - ☐ Before and after measurements (required): _____
  - ☐ Increase in residual limb volume?
  - ☐ Decrease in residual limb volume?
    - ☐ Indicate weight loss/gain: _____
    - ☐ Indicate current sock supply: _____

If replacement device *versus* replacement socket ...

Rationale for new device verses replacement socket: _____

_____

_____

Other comments: _____

_____

_____

Questions: Call Care Management at 800.821.6136, ext. 3100.
Payable benefits are subject to the terms and conditions of the Health Benefit Plan.

GEHA®

Proposed componentry

Hip	Manufacturer: _____ Model/style: _____
Knee	Manufacturer: _____ Model/style: _____
Ankle	Manufacturer: _____ Model/style: _____
Foot	Manufacturer: _____ Model/style: _____
Shoulder	Manufacturer: _____ Model/style: _____
Elbow	Manufacturer: _____ Model/style: _____
Wrist	Manufacturer: _____ Model/style: _____
Terminal device	Manufacturer: _____ Model/style: _____
Vass	Manufacturer: _____ Model/style: _____
Other: _____	Manufacturer: _____ Model/style: _____

Review of this service is pending the completion of this form.
Incomplete forms will be returned; attach additional pages as needed.
To avoid delay in processing your request, please provide all information requested.

IMPORTANT: Please fax completed form and required documents to 816.257.3515 or 816.257.3255.*

*If the patient lives in Texas, call United Healthcare Choice Plus at 877.585.9643.

Questions: Call Care Management at 800.821.6136, ext. 3100.
Payable benefits are subject to the terms and conditions of the Health Benefit Plan.