

PRIOR AUTHORIZATION REQUEST & MEDICAL NECESSITY DOCUMENTATION
 LOW FREQUENCY, NON-CONTACT, NON-THERMAL ULTRASOUND FOR WOUND HEALING

PROVIDER INFORMATION				
Provider Name:		Provider ID #:		
Address:		City/ST/ZIP:		
Ordering Physician:		Phone:		
Treating Clinician:		Phone:		
PATIENT INFORMATION				
Patient Name:		ID #:	DOB:	
Gender: M F	Policy#:	Group#:		
WOUND, PATIENT & TREATMENT HISTORY				
Diagnoses:	<input type="checkbox"/> 707.1	<input type="checkbox"/> 707.8	<input type="checkbox"/> 707.2__	<input type="checkbox"/> Other:
Location of wound:				
Area: ___ sq cm	Depth: ___ cm	Tunneling: Present Absent	Undermining: Present Absent	Duration: ___ days
Exposed structures: Bone Tendon Ligament Muscle		Appearance of bacteria, biofilm, bioburden: Y N		
Circulatory compromise: arterial venous lymphatic mixed	ABI: >0.7 0.4 – 0.7 0.1 – 0.3		TcPO ₂ (mm Hg): >30 20-30 <20	
Exudate: clean purulent	Exudate: ___ ml / day		Wound surface: eschar slough granulation ___ %	
Comorbidities:			Diabetes: Present Absent	
Dressings:		Prior Treatments (debridement, surgical debridement, graft, flap, etc):		
STATEMENT OF MEDICAL NECESSITY				
Based on the above wound characteristics, medical history of the patient, and wound treatment history, I am requesting Prior Authorization for ___ treatments of non-contact, non-thermal low frequency ultrasound for wound healing beginning _____. After two (2) weeks / six (6) treatments, progress toward healing will be evident. If the wound has progressed toward healing as expected, the remainder of the treatments in this Prior Authorization request will be performed. In the absence of treating the patient with non-contact, non-thermal low frequency ultrasound, I expect _____ _____ _____ _____				
BILLING INFORMATION				
CPT 0183T <i>Low frequency, non-contact, non-thermal ultrasound, including topical application(s) when performed, wound assessment, and instruction(s) for ongoing care, per day</i>			Estimated Billed Charge per unit: \$	

I certify that I am the treating clinician identified above, and I certify that the medical necessity information contained in this document is true, accurate, and complete, to the best of my knowledge.

Signature: _____

Date: _____

TO BE COMPLETED BY INSURANCE COMPANY		
Prior Authorization approval for _____ (number) treatments of non-contact, non-thermal low frequency ultrasound between beginning _____ (date).		
Approved by:	Date:	Authorization Reference #:

Please return this document or other confirmation of Prior Authorization approval to my attention at: _____