Limb Prosthetic Authorization Form

For ALL Faxes: 503-416-3637 or toll-free: 800-862-4831

CareOregon®

Date: _____ Provider (Agency/Vendor) Name: _____ Tax ID#:_____

Contact Person: _____ Phone#: _____ Fax#: _____

Member Name:_____ DOB:_____/_____/_____ Subscriber ID#:_____

Prescribing Provider Name:_____ Phone#: _____ Fax#: _____

Primary Dx Code: _____ Description: _____ Dx Code: _____ Description: _____

Amputation: ☐ Left ☐ Right   Amputation occurred within the last 3 years? ☐ Yes ☐ No   If yes, date of amputation: _____/_____/_____

Type of Prosthetic Request: ☐ Preparatory ☐ Definitive ☐ Replacement ☐ Repair   Dates of Service: From _____/_____/_____ To _____/_____/_____

Functional Level: K _____ (medical record documentation required)

For preparatory and definitive prostheses, documentation must address the status of the residual limb, the status of comorbid (e.g. CHF) conditions, functional status (past, current, and anticipated), and motivation to ambulate. As a result, we will need the following documents:

☐ Physical therapy evaluation and progress notes regarding rehabilitation/ambulation potential, if available

☐ Medical history including current progress notes from prescribing

☐ Physician prosthetist notes

For replacement prostheses, the reason a replacement is needed must be clearly documented. If the reason is due to a change in the physiological condition of the individual, documentation must include reason for the change, impact on prosthetic fit, and residential stump measurements (previous and current).

Record applicable HCPCS and appropriate modifier, CPT, or Revenue: Dates of Service: From ____/____/____To____/____/____   ☐ Parenteral ☐ Enteral

Code: _____ Modifier: _____ Description: _____ Quantity: _____ @Price $ _____ =Total $_____

Code: _____ Modifier: _____ Description: _____ Quantity: _____ @Price $ _____ =Total $_____

Code: _____ Modifier: _____ Description: _____ Quantity: _____ @Price $ _____ =Total $_____

Comments: _____

PLEASE NOTE: DMEPOS staff is not authorizing the quoted price or total! Payment is based on contracted rules unless otherwise indicated.   Page_____of_____

Limb Prosthetic Authorization Form, page 2

Date:_____/_____/_____ **Member Name:** _____ **DOB**:_____/_____/_____ **Subscriber ID#:** _____

Code: _____ Modifier: _____ Description: _____ Quantity: _____ @Price $ _____ =Total $ _____

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315 SW Fifth Ave, Portland, OR 97204 • 800-224-4840 • TTY/TDD 711 • careoregon.org

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