WOUND CARE PRIOR AUTHORIZATION FORM

Submit this completed form by fax to **1-833-610-2399,** or on our provider portal:
https://secure.healthx.com/KeyCareAdvantage.Provider
Call 1-844-206-1205 (TTY 711) to speak with a representative.

Members must be referred to in-network facilities and providers unless it is an emergency, other exclusions may apply. Authorized services are not a guarantee of payment. Payment is only authorized for medical services noted below and is subject to the limitations and exclusions as outlined in the Member Handbook/ Certification of Coverage. All requests are reviewed for medical necessity. Incomplete submissions may result in processing delays. Information must be legible.

☐Routine/Standard ☐Serious jeopardy to the member's life or health or ability to regain maximum function

MEMBER INFORMATION			
Member Name:	Member ID:		
Date of Birth:	Member Residence:		
REQUESTING PROVIDER/FACILITY			
Requestor's Name (Print):	Phone Number:	Fax Number:	Date of Request:
Referring Provider (If other than requestor):	Referring Provider: ☐NP/PA ☐PCP ☐Therapy Rep ☐Other		
SERVICING PROVIDER/FACILITY			
Servicing Provider Name:			
NPI/ TIN Number:	Phone Number:	Fax number:	
Address:			
City:	State:	Zip:	
SERVICE TYPE REQUESTED			
☐Initial request ☐Extension of services, Authorization #:			
Current Diagnoses and ICD-10 Code(s):			
Type of Wound Therapy being requested: *If request is for skin grafting please specify number of applications an units being requested.*			

Service:	CPT/HCPCS code:	Site:	Location:
			☐Bilateral ☐ Left ☐Right
			☐Bilateral ☐ Left ☐Right
			☐Bilateral ☐ Left ☐Right
			☐Bilateral ☐ Left ☐Right
			☐Bilateral ☐ Left ☐Right

Negative Pressure Wound Therapy (NPWT): ☐ N/A

☐Disposable/Mechanical NPWT ☐ Electrical NPWT Pump ☐ Single Use NPWT Device

Brand/Name of Device:

Profile Wound #:_____Location: _____ ☐Bilateral ☐ Left ☐Right

How long has the wound been present?

Drainage: ☐ None ☐ Scant ☐ Minimal ☐ Moderate ☐ Heavy/Copious

Type: ☐ Burn ☐ Diabetic Foot Ulcer ☐ Traumatic ☐ Venous Statis Ulcer ☐ Other:_____

Wound Thickness: ☐Deep ☐Full ☐ Partial ☐Superficial Previous treatment:_____

Initial Measurements (cm) Date:

Length:_____width:_____depth:_____cm^2:_____Tunneling:_____Undermining:_____

Current Measurements (cm) Date:

Length:_____width:_____depth:_____cm^2:_____Tunneling:_____Undermining:_____

Profile Wound #:_____Location: _____ ☐Bilateral ☐ Left ☐Right

How long has the wound been present?

Drainage: ☐ None ☐ Scant ☐ Minimal ☐ Moderate ☐ Heavy/Copious

Type: ☐ Burn ☐ Diabetic Foot Ulcer ☐ Traumatic ☐ Venous Statis Ulcer ☐ Other:_____

Wound Thickness: ☐Deep ☐Full ☐ Partial ☐Superficial Previous treatment:_____

Initial Measurements (cm) Date:

Length:_____width:_____depth:_____cm^2:_____Tunneling:_____Undermining:_____

Current Measurements (cm) Date:

Length:_____width:_____depth:_____cm^2:_____Tunneling:_____Undermining:_____

Additional Comments:

CLINICAL INFORMATION

- Please submit written documentation from the medical record to support the procedure, including photos when applicable. Missing this information may delay the decision on your request or may result in Lack of Information denial.
- Documents to attach (where applicable): History and Physical, Therapy Progress Notes, Face-to-face encounter, etc.

OUT-OF NETWORK SERVICES ONLY

- Has the service been scheduled already? ☐Yes ☐No
- Is this a specialized service that no other In-network provider can render? ☐Yes ☐No
- Does the member have an established relationship with the provider that should not be interrupted? ☐ Yes ☐No

  If "Yes", explain (include last visit date):