Medicare Advantage Prior Authorization
Revascularization procedure form

HealthSpring℠

To allow more efficient and accurate processing of your request, fax this completed form and all supporting clinical documentation to 866-287-5834.

Providers must get prior authorization for services before services are provided. Prior authorization isn't guarantee of payment. Payment is subject to coverage, patient eligibility and contractual limitations.

Date / /	**Please check request type**
☐ Standard request If the service has already been provided, please follow retroactive process and submit claim.	☐ Expedited request – may take up to 72 hours **I certify that waiting for a decision under the standard time frame could place the member's life, health or ability to regain maximum function in serious jeopardy.**
Member name	Member ID
Member date of birth	Date of service
Requesting provider name	National Provider Identifier
Contact name	Contact phone
Contact fax	Name of facility, place of service or specialist
Medicare Advantage only: Is provider part of a regulated facility? ☐ Yes ☐ No	
Diagnosis	ICD-10 diagnostic codes
Procedure (Select a procedure) Procedure (Select a procedure) Procedure (Select a procedure) Procedure (Select a procedure)	
Current Procedural Terminology (CPT®) codes Provide all planned CPT codes. For lower extremity revascularization, submit only those codes that apply to the particular region to be addressed.	
Symptoms of claudication ☐ Lower extremity edema ☐ Leg pain with rest ☐ Leg pain with ambulation	

Conservative treatment for claudication

☐ Exercise ☐ Smoking cessation ☐ Medications

Medications tried _____

Symptoms of critical or chronic limb ischemia

☐ Ischemic rest pain ☐ Lower extremity non-healing wound ulcer ☐ Gangrene

Symptoms of acute limb ischemia

☐ Pain ☐ Pallor (cyanosis) ☐ Pulselessness ☐ Coldness ☐ Paresthesias ☐ Paralysis

Functional limitations

☐ Impairment of activities of daily living ☐ Inability to complete job functions ☐ Recreational activities affected

Other diagnostic studies performed

☐ Ankle brachial index _____ ☐ Left ☐ Right Date _____

or

☐ Monophasic waveform by ultrasound _____ Date _____

Provide any additional clinical information if applicable