PRIOR AUTHORIZATION for MECHANICAL STRETCHING DEVICES for CONTRACTURE and JOINT STIFFNESS

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Customer Service at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

Date Requested:	Name (Last, First MI):	DOB:	Age:	PEHP ID #:

Section II: PROVIDER INFORMATION

Ordering Provider:		*Ordering* Provider Address:			
Provider NPI #:	**Provider TIN #:**	**Contact Person:**	**Phone:** ( )	**Facsimile:** ( )	**Email Address:**

Rendering Provider:		*Rendering* Provider Address:			
Provider NPI #:	**Provider TIN #:**	**Contact Person:**	**Phone:** ( )	**Facsimile:** ( )	**Email Address:**

Section III: PRE-AUTHORIZATION REQUEST

A. Nature of Request: *Please check.* ☐ Pre-Auth ☐ Retrospective Auth	B. Requested Date(s) of Service: From: To:	C. Primary Diagnosis/ICD-10 Code:	D. Secondary Diagnosis/ICD-10 Code:
E. Date of Injury and/or Surgery:	**F. Description of Injury and/or Surgery:**	**G. Injury/Surgery Related to a Motor Vehicle Accident?** ☐ Yes ☐ No	**H. Injury/Surgery Related to a Work-Related Injury?** ☐ Yes ☐ No

I. Type of Mechanical Stretching Device Being Requested: ***Please check all that apply.***

1. ☐ Dynamic Splinting Device
2. ☐ Patient-Actuated Serial Stretch (PASS) Device (*e.g., **ERMI** Ankle, Knee, or Shoulder Flexionator, ERMI Elbow, Knee, or MPJ Extensionator, **JAS EZ** [ankle, elbow, finger, knee extension or flexion, pronation/ supination, shoulder, toe, and wrist], and knee extension devices [e.g., Elite Seat]*).
3. ☐ Static Progressive Stretch (SPS) Splint Devices

J. Service/Durable Medical Equipment (DME) Requested:

Service/DME Description: _____ CPT/HCPCS code: _____ Joint: _____ ☐ Left ☐ Right ☐ Bilateral

Service/DME Description: _____ CPT/HCPCS code: _____ Joint: _____ ☐ Left ☐ Right ☐ Bilateral

(Please check device being requested.) QUESTION	YES	NO	COMMENTS/NOTES
K. ☐ Dynamic Splinting Devices: 1. Is the dynamic splinting device to be used on the elbow, finger, knee, toe, or wrist joint?	☐	☐	
2. Is the dynamic splinting device to be used adjunctively with physical therapy *and* does the patient have documented signs and symptoms of significant motion stiffness/loss in the sub-acute injury or post-operative period (i.e., at least 3 weeks after injury or surgery)?	☐	☐	
3. Does the patient have a prior documented history of motion stiffness/loss in a joint, have had a surgery or procedure done to improve motion to that joint, *and* are in the acute post-operative period following a second or subsequent surgery or procedure?	☐	☐	
4. Is the patient having surgery for a "chronic" condition (no significant change in motion for a 4-month period)?	☐	☐	
5. Is the dynamic splinting device being used prophylactically in the management of a chronic contracture and joint stiffness due to joint trauma, fractures, burns, head & spinal cord injuries, rheumatoid arthritis, multiple sclerosis, muscular dystrophy, or cerebral palsy?	☐	☐	
6. Is the dynamic splinting device being used for any of the following conditions? ***Please check all that apply.*** ☐ Ankle injury ☐ Carpal Tunnel Syndrome ☐ Cerebral Palsy ☐ Foot drop associated with neuromuscular diseases ☐ Hallux valgus ☐ Head injury ☐ Improvement of outcomes following Botox injection for treatment of limb spasticity ☐ Multiple Sclerosis ☐ Muscular Dystrophy ☐ Plantar fasciitis ☐ Rheumatoid Arthritis ☐ Shoulder injury ☐ Spinal cord injury ☐ Stroke ☐ Trismus ("Lockjaw")	☐	☐	
7. Is one of the following dynamic splinting systems being requested? ***Please check or specify.*** a. ☐ Advance® Dynamic ROM b. ☐ Dynasplint® c. ☐ EMPI Advance Dynamic ROM d. ☐ LMB Pro-Glide™ e. ☐ Pro-Glide Dynamic ROM™ f. ☐ SaeboFlex® g. ☐ SaeboMAS h. ☐ SaeboReach™ i. ☐ Stat-A-Dyn j. ☐ Ultraflex k. ☐ Other: _____	☐	☐	

Additional Comments:

By submitting this form, I attest that the information provided is true and accurate to the best of my knowledge.

Please fax completed form and medical records to 801-366-7449.