PRIOR AUTHORIZATION for WOUND CARE

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

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

Section II: PROVIDER INFORMATION

Date Requested:		Service Provider Name:
Service Provider NPI #:	Service Provider Tax ID #:	Service Provider Address:

Contact Person:	Phone: ( )	Facsimile: ( )

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.* ☐ Auth Extension ☐ Pre-Auth ☐ Retro Auth ☐ Urgent	**Requested Date of Service:**	**Place of Service:** *Please check.* ☐ Ambulatory Surgical Center ☐ Inpatient ☐ Office ☐ Outpatient

Facility Name:	**Facility NPI #:**	**Facility Tax ID #:**

Primary Diagnosis/ICD-10 Code:	**Secondary Diagnosis/ICD-10 Code:**

A. Type of Wound Therapy being requested: **If request is for skin grafting please specify number of applications & units being requested.*

Service: ________________________ CPT/HCPCS code: ____________ Wound Site: ____________ ☐ Bilateral ☐ Left ☐ Right

Service: ________________________ CPT/HCPCS code: ____________ Wound Site: ____________ ☐ Bilateral ☐ Left ☐ Right

Service: ________________________ CPT/HCPCS code: ____________ Wound Site: ____________ ☐ Bilateral ☐ Left ☐ Right

Service: ________________________ CPT/HCPCS code: ____________ Wound Site: ____________ ☐ Bilateral ☐ Left ☐ Right

B. For Negative Pressure Wound Therapy (NPWT): **Please check which type of NPWT is in use and fill in brand/name of device.* **☐ N/A**

1. ☐ Disposable/Mechanical NPWT (e.g., SNAP Therapy) 2. ☐ Electrical NPWT Pump 3. ☐ Single-Use NPWT Device

Brand/Name of device: ____

C. For Lower Extremity Skin Grafts (Wound Closure): ☐ Bilateral ☐ Left ☐ Right **Please answer/check each question.* **☐ N/A**

1. **To verify adequate blood supply, are pedal pulses palpable or is the Ankle-Brachial Index (ABI) $\geq$ 0.70?** ☐ No ☐ Yes
2. **Current hemoglobin A1C (HbA1C) for patients with type I or type II Diabetes Mellitus:** Date Drawn: ____________ Result: ____________

D. 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 ☐ Pressure Ulcer ☐ Traumatic ☐ Venous Statis Ulcer ☐ Other____________________

Wound Thickness: ☐ Deep ☐ Full ☐ Partial ☐ Superficial **Previous failed treatment:** ____________________

INITIAL Measurements (centimeter/cm):

Date: __________ *Length* ______ *Width* ______ *Depth* ______ *Square Centimeter* ______ *Tunneling* ______ *Undermining* ______

CURRENT Measurements (cm):

Date: __________ *Length* ______ *Width* ______ *Depth* ______ *Square Centimeter* ______ *Tunneling* ______ *Undermining* ______

E. 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 ☐ Pressure Ulcer ☐ Traumatic ☐ Venous Statis Ulcer ☐ Other____________________

Wound Thickness: ☐ Deep ☐ Full ☐ Partial ☐ Superficial **Previous failed treatment:** ____________________

INITIAL Measurements (centimeter/cm):

Date: __________ *Length* ______ *Width* ______ *Depth* ______ *Square Centimeter* ______ *Tunneling* ______ *Undermining* ______

CURRENT Measurements (cm):

Date: __________ *Length* ______ *Width* ______ *Depth* ______ *Square Centimeter* ______ *Tunneling* ______ *Undermining* ______

Additional Comments:

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