BlueChoice®
HealthPlan of South Carolina

Medicaid

Review Request
for External Insulin Infusion Pump

Please fax the completed form to **1-800-823-5520.**
If you have questions, call **1-866-902-1689** during regular business hours.
.

Policy Last Review Date: 05/21/09	Policy Effective Date: 07/15/09	Provider Tool Effective Date: 8/10/09

Member Name:	Date of Birth:
Insurance Identification Number:	Member Phone Number:

Ordering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:

Rendering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:

Facility Name:	Facility ID Number:
Facility Address:	

Date/Date Range of Service:	Place of Service: ☐Home ☐ Inpatient ☐Outpatient ☐ Other: _____
Service Requested (CPT if known):	
Diagnosis (ICD-9) if known:	

www.BlueChoiceSCMedicaid.com

BlueChoice HealthPlan is an independent licensee of the Blue Cross and Blue Shield Association.
Medicaid managed care administered by WellPoint Partnership Plan, LLC, an independent company.

1109 SCW2672 04/20/10

Please check all that apply to the member:

☐ Request is for an initial external (portable) insulin pump

☐ Request is for a replacement pump that is out of warranty, malfunctioning and cannot be refurbished

☐ Request is to upgrade/replace a functioning or warranted external insulin infusion pump.

☐ Request is for a disposable external insulin infusion pump with wireless communication capability to a hand-held control unit (e.g. OmniPod®)

☐ Request is for an external insulin pump with wireless communication to a compatible continuous glucose monitoring sensor/transmitter (e.g. Paradigm® REAL-Time System). If checked, please submit BlueChoice HealthPlan Medicaid Provider Tool for Medical Policy DME.00005 along with this tool.

- ☐ Member is not currently using: a functioning continuous glucose monitor
- ☐ Member is not currently using: an external insulin pump without wireless integration capability

☐ Request is for treatment of insulin-dependent diabetes and any of the following apply:

- ☐ Member has been seen by his or her medical provider at least 4 times within the last year.
- ☐ A comprehensive diabetes education program has been completed within past 2 years.
- ☐ Member follows a program of multiple daily insulin injections
- ☐ Member had frequent self adjustments of insulin doses for the past six months
- ☐ Member is self-monitoring blood sugar at least 4 times per day for the past month
- ☐ Member has glycosulated hemoglobin (HbA1C) level greater than 7.0%
- ☐ Brittle diabetes with documentation of repeated clinical episodes of hypoglycemia or ketoacidosis resulting in recurrent and/or prolonged hospitalization
- ☐ History of recurring hypoglycemia or severe glycemic excursions
- ☐ Wide fluctuations in blood glucose before mealtime
- ☐ Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl recurrent and/or prolonged hospitalization

☐ Request is for pre-conception or pregnancy to reduce the incidence of fetal mortality or anomaly

☐ Request is for a member who successfully used a continuous insulin pump prior to enrollment and had documented frequency of glucose self-testing at least 4 times per day during the month prior to enrollment.

☐ Request is for a pediatric member who requires a larger insulin reservoir. Please supply the following information:

Current insulin pump reservoir volume: ____________________________________
Current insulin needs: ____
Current insulin change out frequency required to meet patient needs: _____________

This request is being submitted:

☐ Pre-Claim

☐ Post-Claim. If checked, please attach the claim or indicate the claim number: ___________________________________

☐ By checking this box, I attest the information provided is true and accurate to the best of my knowledge. I understand that BlueChoice HealthPlan Medicaid may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

____ ____________________________

Name and Title of Provider or Provider Representative Completing Form (Please Print)* | Date

***The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted.**