

**Review Request
for Hyperbaric Oxygen Therapy**

Please fax the completed form to **1-800-823-5520**.

If you have questions, call **1-866-902-1689** during regular business hours.

| | |
|--|---|
| 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: <input type="checkbox"/> Home <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Other: _____ |
| Service Requested (CPT if known): | |
| Diagnosis (ICD-9) if known: | |

Please check all that apply to the member:

Initial Request

Request is for:

- Systemic hyperbaric oxygen pressurization performed in accordance with Undersea and Hyperbaric Medical Society guidelines
- Topical hyperbaric oxygen
- Limb-specific hyperbaric oxygen pressurization
- Other: _____

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Request is for treatment of any of the following conditions (please check all that apply to the member):

- | | |
|---|--|
| <input type="checkbox"/> Acute peripheral arterial insufficiency | <input type="checkbox"/> Acute thermal burns: deep 2 nd degree or 3 rd degree in nature |
| <input type="checkbox"/> Acute traumatic ischemia | <input type="checkbox"/> Carbon monoxide poisoning |
| <input type="checkbox"/> Central retinal artery occlusion (CRAO) | <input type="checkbox"/> Cyanide poisoning |
| <input type="checkbox"/> Chronic refractory osteomyelitis (refractory osteomyelitis) | <input type="checkbox"/> Compartment syndrome |
| <input type="checkbox"/> Compromised skin graft / flap (enhancement of healing in selected wounds) | <input type="checkbox"/> Delayed radiation injury, including osteoradionecrosis, soft tissue radiation necrosis and radiation cystitis |
| <input type="checkbox"/> Decompression sickness | <input type="checkbox"/> Crush injuries |
| <input type="checkbox"/> Gas or air embolism | <input type="checkbox"/> Gas gangrene (i.e., clostridial myositis and myonecrosis) |
| <input type="checkbox"/> Intracranial abscess | <input type="checkbox"/> Necrotizing soft-tissue infections |
| <input type="checkbox"/> Prophylactic pre & post treatment for members undergoing Dental surgery of a radiated jaw | <input type="checkbox"/> Severe anemia with exceptional blood loss: when transfusion is impossible or delayed |
| <input type="checkbox"/> Chronic non-healing wounds which have not responded to 30 days of appropriate conservative treatment and which show continued response when evaluated at 30-day intervals. | <input type="checkbox"/> Other: _____ |

Continuation Request

- Request is for continued systemic hyperbaric oxygen pressurization
- Documentation of the monthly assessment of the wound(s) dimensions and characteristics by a licensed health care professional:
 - Date _____ Wound measurements (cm) _____ Wound characteristics _____
 - Date _____ Wound measurements (cm) _____ Wound characteristics _____
 - Date _____ Wound measurements (cm) _____ Wound characteristics _____
 - Date _____ Wound measurements (cm) _____ Wound characteristics _____
- The wound fails to show measurable signs of healing

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 _____ Date _____
Completing Form (Please Print)*

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