BlueChoice®
HealthPlan of South Carolina

Medicaid

Review Request
for Lower Limb Prosthesis

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: ☐Home ☐ Inpatient ☐Outpatient ☐ Other: _____
Service Requested (CPT if known):	
Diagnosis (ICD-9) if known:	Procedure will be done on (if applicable): ☐ Left ☐Right ☐Bilateral

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 SCW2678 04/20/10

Functional Level:

Please check the appropriate functional level that applies to the member before proceeding to the specific request:

- ☐ **Level 0:** Does not have the ability or potential to ambulate or transfer safely with or without assistance and prosthesis does not enhance his or her quality of life or mobility.
- ☐ **Level 1:** Has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.
- ☐ **Level 2:** Has the ability or potential for ambulation with the ability to traverse low-level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.
- ☐ **Level 3:** Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.
- ☐ **Level 4:** Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

Lower Limb: Prosthesis Fitting and Selection (check all that apply):

- ☐ Request is for a Lower Limb Prosthesis
  - ☐ The prosthesis is prescribed by a physician
  - ☐ The member will reach or maintain a defined functional state within a reasonable period of time
  - ☐ The member needs prosthesis for ambulation
  - ☐ The member's rehabilitation potential is based on functional levels as outlined above
  - ☐ The following anatomy-specific criteria apply (check all that apply)
    - ☐ Ankle(s) – request is for axial rotation unit
    - ☐ Knee(s)
      - ☐ Request is for fluid or pneumatic knees
      - ☐ Request is for a knee system other than fluid or pneumatic
      - ☐ Please describe: ______________________________
    - ☐ Sockets
      - ☐ There have been no more than 2 test (diagnostic) sockets
      - ☐ There is documentation of changes in the residual limb
      - ☐ There is documentation of functional need changes
      - ☐ There is documentation of irreparable damage
      - ☐ There is documentation of wear/tear due to excessive member weight or prosthetic demands of a very active amputee
    - ☐ Feet
      - ☐ Request is for an external keel SACH foot or single axis ankle/foot
      - ☐ Request is for a flexible-keel foot or multi-axial ankle/foot
      - ☐ Request is for a flex foot system
      - ☐ Request is for a energy storing foot
      - ☐ Request is for a multi-axial ankle/foot
      - ☐ Request is for a dynamic response / flex-walk system (or equal)
      - ☐ Request is for a shank foot system with vertical loading pylon
    - ☐ Other: ______________________________

Prosthesis Accessories

- ☐ Request is for a stump stocking
- ☐ Request is for a harness
- ☐ Request is for another type of accessory. Please list: ______________________________
- ☐ This accessory/appliance will aid in or is essential to the effective use of the limb
- ☐ Other: ______________________________

Prosthesis Repairs

☐ Repair to prosthesis is needed to make the prosthesis functional

☐ Other: ____________________

Prosthesis Maintenance

☐ Maintenance is being done by the prosthetist as necessitated by manufacturer's recommendations or the construction of the prosthesis

☐ Other: ____________________

Prosthesis Adjustments

☐ Adjustment is required due to wear and tear

☐ Adjustment is required due to a change in the member's condition

☐ Other: ____________________

Prosthesis Replacement

☐ Request is to replace the prosthesis

☐ Request is to replace a prosthetic component

☐ Replacement is needed due to a change in the physiological condition of the member

☐ Replacement is needed due to irreparable wear of the device or a part of the device

☐ The cost to repair the device would be more than 60% of the cost to replace the device or the part being replaced.

☐ Other: ____________________

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.**