

Review Request for Prefabricated and Prophylactic Knee Braces

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: 08/31/09
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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:

- Request is for a prefabricated functional or rehabilitation knee brace
- Request is for a prophylactic knee brace
- Other: _____

- Member has documented anterior or posterior cruciate ligament (ACL or PCL) tears or functional instability episodes due to cruciate ligament insufficiency and elects non-surgical treatment.
- Member with Grade II or III medial collateral or lateral collateral ligament sprain to support ambulation when the use of a hinged brace allows for controlled joint motion.
- Member with posterior cruciate or posterior lateral reconstruction, including if the member underwent reconstruction after a knee dislocation.
- Member had recent surgery for anterior cruciate ligament repair and is in the post-operative recovery phase.
- Member had recent surgery for meniscal cartilage repair and is in the post-operative recovery phase.
- Member has major ligament and bony reconstruction above the knee such as patella or quadriceps tendon repair, medial and lateral collateral ligament repair.
- Member has major fractures requiring early post-operative motion such as patella fracture or a tibial plateau fracture.
- Member has osteoarthritis of the knee (unicompartmental) (check all that apply):
 - Member is a candidate for high tibial osteotomy or total knee arthroplasty (replacement) and may elect non-surgical treatment.
 - Knee brace is needed to predict the success of high tibial osteotomy versus total knee athroplasy.
 - Member has severe patellofemoral arthrosis in conjunction with medial or lateral compartment arthrosis.
 - Other: _____

- 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.**