Review Request
for Prothrombin Time Self-Monitoring Devices

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: 02/26/09	**Policy Effective Date: 04/22/09**	**Provider Tool Effective Date: 08/31/09**

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:	

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.

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Please check all that apply to the member:

☐ Request is for a home prothrombin time self-monitoring INR device which is prescribed by the MD

☐ Member requires long-term (>1 year) anticoagulation with Warfarin

☐ Member requires at least weekly determinations of INR values

☐ Member or caregiver demonstrates the technical skill and willingness to use the monitor and the ability to comprehend the basic aspects of oral coagulation control including the risks.

☐ Member or caregiver training is provided under the supervision of a physician.

☐ Training includes:

- ☐ Demonstrating use and care of the INR monitor
- ☐ Demonstration of obtaining a blood sample
- ☐ Instructions were provided for reporting of home INR results
- ☐ Documentation exists validating that member or caregiver has the ability to perform the test
- ☐ Member demonstrates compliance and cooperation with medication administration and monitoring of values

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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.**