BlueChoice® HealthPlan of South Carolina

Medicaid

Review Request

for Spinal Orthoses: Thoracic-Lumbar-Sacral (TLSO), Lumbar-Sacral (LSO), and Lumbar

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:	

Request is for the following:

☐ Prefabricated thoracic-lumbar-sacral orthoses (TLSO)
☐ Prefabricated lumbar-sacral orthoses (LSO)
☐ Prefabricated lumbar orthoses with custom fitting
☐ Other: ____________________

☐ Reduce pain by restricting mobility of the trunk
☐ Facilitate healing following an injury to the spine or related soft tissues
☐ Facilitate healing following a surgical procedure on the spine or related soft tissue
☐ Otherwise support weak spinal muscles or a deformed spine
☐ To allow the member to perform leisure or recreational activities
☐ Other: ____________________

www.BlueChoiceSCMedicaid.com

Request is for the following:

☐ Custom fabricated or molded spinal orthoses
☐ Other: ______________________________

☐ For the treatment of scoliosis
☐ For the treatment of an underlying deformity or body somatotype which would preclude the use of a prefabricated brace
Please provide reason: ______________________________
☐ To allow the member to perform leisure or recreational activities
☐ 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.**