

**Review Request
 for Ultraviolet Light, including Laser Therapy,
 for the Treatment of Skin Disorders**

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: 11/20/08	Policy Effective Date: 01/14/09	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 member to receive Psoralen with Ultraviolet A (PUVA) (check all that apply):
- | | |
|---|---|
| <input type="checkbox"/> Member has acute/chronic pityriasis lichenoides | <input type="checkbox"/> Member has atopic dermatitis |
| <input type="checkbox"/> Member has eczema | <input type="checkbox"/> Member has lichen planus |
| <input type="checkbox"/> Member has mycosis fungoides (cutaneous T-cell lymphoma) | <input type="checkbox"/> Member has psoriasis |
| <input type="checkbox"/> Member has vitiligo | |
| <input type="checkbox"/> Other: _____ | |
- Request is for Ultraviolet A or B therapy (with or without topical preparations, e.g., emollients or tar, also known as Goeckerman or modified Goeckerman therapy) (check all that apply):
- | | |
|---|---|
| <input type="checkbox"/> Member has atopic dermatitis | <input type="checkbox"/> Member has chronic urticaria |
| <input type="checkbox"/> Member has eczema | <input type="checkbox"/> Member has lichen planus |
| <input type="checkbox"/> Member has mycosis fungoides (cutaneous T-cell lymphoma) | <input type="checkbox"/> Member has pityriasis lichenoides |
| <input type="checkbox"/> Member has pityriasis rosea | <input type="checkbox"/> Member has pruritus of renal failure |
| <input type="checkbox"/> Member has psoriasis | <input type="checkbox"/> Member has vitiligo |
| <input type="checkbox"/> Other: _____ | |
- Request is for Ultraviolet B light therapy to be administered in the home (check all that apply):
- | | |
|---|---|
| <input type="checkbox"/> Member is under physician's supervision with regular scheduled exams | <input type="checkbox"/> Member has mycosis fungoides |
| <input type="checkbox"/> Member has lichen planus | <input type="checkbox"/> Member has pruritus of hepatic disease |
| <input type="checkbox"/> Member has pityriasis lichenoides | <input type="checkbox"/> Member has severe atopic dermatitis |
| <input type="checkbox"/> Member has pruritus of renal failure | |
| <input type="checkbox"/> Member has mild to moderate psoriasis that has failed standard treatment | |
| <input type="checkbox"/> Member has severe psoriasis | |
| <input type="checkbox"/> Member has mild to moderate atopic dermatitis that has failed standard treatment | |
| <input type="checkbox"/> Other: _____ | |
- Request is for use of Ultraviolet B laser therapy (e.g., Xenon-Chloride, Excimer) for the treatment of psoriasis: (check all that apply)
- | |
|--|
| <input type="checkbox"/> The member's psoriasis is limited to less than or equal to 10% on the member's body surface area |
| <input type="checkbox"/> The member has failed a previous two-month long trial of conservative therapy with topical agents, with or without standard non-laser ultraviolet actinotherapy |
| <input type="checkbox"/> 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.**