

Review Request for
Functional Endoscopic Sinus Surgery

Please fax the completed form to **1-800-823-5520**.

If you have questions, call **1-866-902-1689** during regular business hours.

Provider Data Collection Tool Based on Medical Policy CG-SURG-24



Medicaid

Policy Last Review Date: 08/27/2009		Policy Effective Date: 10/21/2009		Provider Tool Effective Date: 04/14/2010	
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		
Service Requested (CPT if known):			<input type="checkbox"/> Outpatient <input type="checkbox"/> Other: _____		
Diagnosis (ICD-9) if known:					

Please check all that apply to the member:

- Request is for functional endoscopic sinus surgery for: (check all that apply):
- Sinusitis
 - Polyposis
 - Sinus tumor
 - Other (please describe): _____

Member has the following conditions: (check all that apply):

- Member has suspected tumor seen on: (check all that apply)
 - Imaging
 - Physical examination
 - Endoscopy
- Member has suppurative (pus forming) complications: (check all that apply)
 - Subperiosteal abscess
 - Brain abscess
 - Other (please describe): _____
- Member has chronic polyposis
 - Symptoms are unresponsive to medical therapy

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- Member has allergic fungal sinusitis as indicated by: (check all that apply)
 - Nasal polyposis
 - Positive CT findings
 - Eosinophilic mucus
 - Member has a mucocele
 - Member has recurrent sinusitis that: (check all that apply)
 - Triggers pulmonary disease (e.g. asthma, cystic fibrosis)
 - Aggravates pulmonary disease (e.g. asthma, cystic fibrosis)
 - Member has uncomplicated sinusitis and: (check all that apply)
 - Four or more documented episodes of acute rhinosinusitis in one year
 - Chronic sinusitis that interferes with lifestyle
 - Maximal medical therapy has been attempted as indicated by: (check all that apply)
 - Antibiotic therapy
 - Trial of inhaled steroids
 - Nasal lavage
 - Allergy assessment
 - Member has abnormal findings from diagnostic work-up as indicated by: (check all that apply)
 - Findings suggestive of obstruction on CT
 - Findings suggestive of active infection on CT
 - Significant obstructive symptoms due to polyposis
 - Symptoms persist or recur after: (check all that apply)
 - Oral corticosteroid treatment
 - Topical corticosteroid treatment
 - Nasal endoscopy findings suggestive of significant disease
 - Member has a fungal mycetoma
 - Member has failed some other sinus surgery
 - Member has cerebrospinal fluid rhinorrhea
 - Member has an encephalocele
 - Member has posterior epistaxis
 - Member has persistent facial pain after other causes are ruled out
 - Other (please describe): _____
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This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number: _____

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 _____ Date _____
Completing Form and Attestation (Please Print)*

*** The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted.**