

**VERMONT MEDICAID PRE-PROCEDURE REQUEST FORM**

Date of Request: \_\_\_\_\_

Date, if Procedure has been scheduled: \_\_\_\_\_  N/A: Procedure has not been scheduledProcedure is:  Elective  Urgent  Emergent (Does not require prior authorization).Setting where procedure will be performed:  Hospital Outpatient  Hospital Inpatient

Patient Name: (last) \_\_\_\_\_ (first) \_\_\_\_\_

Medicaid ID Number: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Gender: M F (please circle)

<b>Provider Information</b>
-----------------------------

Requesting Provider Name: \_\_\_\_\_ VT. Medicaid Provider Number: \_\_\_\_\_

Requesting Provider NPI: \_\_\_\_\_ Taxonomy: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Office Contact Person: \_\_\_\_\_ Telephone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

<b>Facility Information</b>
-----------------------------

Facility Name: \_\_\_\_\_ VT. Medicaid Provider Number: \_\_\_\_\_

Facility NPI: \_\_\_\_\_ Taxonomy: \_\_\_\_\_

Facility Address: \_\_\_\_\_

Office Contact Person: \_\_\_\_\_ Telephone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

<b>Procedure(s) Requested</b>
-------------------------------

Procedure: _____	Diagnosis: _____	ICD-9 Code: _____
------------------	------------------	-------------------

ICD-9 Procedure Code: _____	Diagnosis: _____	ICD-9 Code: _____
-----------------------------	------------------	-------------------

CPT Procedure Code: _____	Diagnosis: _____	ICD-9 Code: _____
---------------------------	------------------	-------------------

Procedure: _____	Diagnosis: _____	ICD-9 Code: _____
------------------	------------------	-------------------

ICD-9 Procedure Code: _____	Diagnosis: _____	ICD-9 Code: _____
-----------------------------	------------------	-------------------

CPT Procedure Code: _____	Diagnosis: _____	ICD-9 Code: _____
---------------------------	------------------	-------------------

Procedure: _____	Diagnosis: _____	ICD-9 Code: _____
------------------	------------------	-------------------

ICD-9 Procedure Code: _____	Diagnosis: _____	ICD-9 Code: _____
-----------------------------	------------------	-------------------

CPT Procedure Code: _____	Diagnosis: _____	ICD-9 Code: _____
---------------------------	------------------	-------------------

Patient Medicaid Number: \_\_\_\_\_

**Medical Information – All Procedures**

**Provide convincing information to justify each procedure on page 1.**

Have any other related procedures been done previously for the same problem or condition?

No  Yes  If yes, when: Month \_\_\_\_\_ Year \_\_\_\_\_ Specify results and/or attach reports.

Provide pertinent medical information and rationale for the procedure(s) being requested. Include all conservative treatments/ interventions and the results/outcomes.

**Supporting Documentation** (History & Physical, prior surgery, consultations, photos, if applicable, etc.) N/A

- Date: \_\_\_\_\_ Treatment: \_\_\_\_\_  
Results: \_\_\_\_\_
- Date: \_\_\_\_\_ Treatment: \_\_\_\_\_  
Results: \_\_\_\_\_
- Date: \_\_\_\_\_ Treatment: \_\_\_\_\_  
Results: \_\_\_\_\_

**If this Prior Authorization request is for a Hysterectomy or Bariatric Surgery, please complete the appropriate attached page.**

**X** Signature of Requesting Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Medicaid Number: \_\_\_\_\_

**Hysterectomy**

**Hysterectomy:** Attach a copy of the latest **HISTORY and PHYSICAL**. Complete the following if the information is not included.

**1. Medication Management (OCP, GnRH agonists, NSAIDS, Iron, etc.):** N/A

▪ Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration, including dates: \_\_\_\_\_

Results: \_\_\_\_\_

▪ Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration, including dates: \_\_\_\_\_

Results: \_\_\_\_\_

**2. Diagnostic Test/Surgery/Procedures/Imaging:** N/A

▪ Date: \_\_\_\_\_ Name: \_\_\_\_\_

Results: \_\_\_\_\_

▪ Date: \_\_\_\_\_ Name: \_\_\_\_\_

Results: \_\_\_\_\_

**3. Pathology Reports (Labs – TSH, PAP):** N/A

▪ Date: \_\_\_\_\_ Name: \_\_\_\_\_

Results: \_\_\_\_\_

▪ Date: \_\_\_\_\_ Name: \_\_\_\_\_

Results: \_\_\_\_\_

**4. Sterilization** Yes  No  If yes, Date: \_\_\_\_\_

**5. Future Childbearing desired?** Yes  No

**COMMENTS:**

**X** Signature of Requesting Provider: \_\_\_\_\_ Date: \_\_\_\_\_

MEDICAL RECORDS MAY BE SUBJECT TO AN OVHA MEDICAL RECORD RETRO REVIEW.

Patient Medicaid Number: \_\_\_\_\_

**Bariatric Surgery**

1. **Current** Weight: \_\_\_\_\_ Height: \_\_\_\_\_ BMI: \_\_\_\_\_ Age: \_\_\_\_\_

2. How long has the patient been obese?    Less then 5 years                       More than 5 years

3. History of current substance abuse?    Yes                       No

If yes, specify: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. List impacting medical and functional factors/co-morbidities: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. TSH normal:    Yes     No                       If yes, Date test performed: \_\_\_\_\_

6. Has the patient been on a physician/dietician supervised diet program for six months?    Yes     No

7. Does the patient understand surgical risk and post procedure compliance and follow-up requirements?    Yes     No

8. What is the plan for post-surgical follow-up? \_\_\_\_\_  
\_\_\_\_\_

**COMMENTS:**

**X** Signature of Requesting Provider: \_\_\_\_\_ Date: \_\_\_\_\_

MEDICAL RECORDS MAY BE SUBJECT TO AN OVHA MEDICAL RECORD RETRO REVIEW.