HealthPartners®

Prior Authorization for Hip Arthroplasty review

Fax completed forms to **(952)853-8713.** Call Utilization Management (UM) at **(952)883-6333**with questions. Incomplete forms will be returned. **Submit clinical documentation** to support your request. Sign in at healthpartners.com/provider and use the Authorizations and referrals link to check the status of your prior authorization request.

Member information

First Name _____ MI _____ Last Name _____

HealthPartners ID # _____ DOB _____

Requester information

Form completed by: First Name _____ Last Name _____

Your business name _____

Your business street address _____

Your business city _____ Your business state _____ Your business zip _____

Phone* _____ Fax** _____

Ordering provider information

Provider first name _____ Provider last name _____

Specialty _____ NPI _____

Clinic name _____

Clinic street address _____

Clinic city _____ Clinic state _____ Clinic zip _____

Clinic tax ID (claim may be rejected if incorrect) _____

Email _____ Phone* _____ Fax** _____

Procedural provider information

Provider first name _____ Provider last name _____

Specialty _____ NPI _____

Clinic name _____

Clinic street address _____

Clinic city _____ Clinic state _____ Clinic zip _____

Clinic tax ID (claim may be rejected if incorrect) _____

Email _____ Phone* _____ Fax** _____

Facility site for procedure or surgery

Facility name _____

Facility street address _____

Facility City _____ Facility state _____ Facility zip _____

Billing tax ID (claim may be rejected if incorrect) _____

Phone* _____ Fax** _____

**Confidential voicemail required*
***For outcome notification*

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Procedure or surgery

Only include codes requiring prior authorization; other codes will not be addressed

Primary diagnosis code _____ Description _____

Secondary diagnosis code _____ Description _____

Procedure code(s) _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

Procedure(s) or surgery description _____

_____

Proposed date of procedure _____ or ☐ TBD

Will waiting the standard review time seriously jeopardize member's health, life or ability to regain maximum functioning? ☐ yes ☐ no

Clinical reason for urgency (not scheduling issues) _____

Please submit all the following:

- **Clinical document that supports the medical need for the hip arthroplasty**
  - Documentation that treatment is needed for disabling pain or functional disability **AND**
  - Documentation that treatment is needed for degenerative joint disease indicated by:
    - Radiographic report(s) (plain radiographs, MRI/CT) documenting the indication for the hip surgery: subchondral cysts, joint space narrowing, joint subluxation, subchondral sclerosis, etc..

    AND
  - Documentation of Conservative measures
    - Physical therapy notes (must correspond to the current episode of pain)
    - Attempts of weight loss
    - Use of NSAIDs or other pain management trial
    - Activity modification trial

    OR
  - Documentation that patient is not a candidate for conservative measures and why (example: osteotomy or hemiarthroplasty)

Replacement/Revision

- **Clinical Documentation that supports the medical need for a hip Revision or resurfacing of arthoplasty**
  - Radiographic reports(s) (plan radiographs, MRI/CT) documenting the indication for hip revision