Prior Authorization Request (PAR) for Blood Pressure Monitor (A4670)

*Please **FILL OUT BOTH PAGES**, sign urgently and fax to us at: (800) 231-0352.*

Accepted insurance plans: Medicaid (all plans) • Denver Health Medical Plan • Tricare West • Colorado Access • Rocky Mountain Health Plans (only Medicaid & CHP+) • CHP+ (excluding Kaiser CHP+)

Prescribing Provider:

Name: _____ **NPI:** _____ **License #:** _____

Signature: _____ **Date:** / / **Email:** _____

Lactation Dept/ Manager Phone: _____ **Facility Name:** _____

Patient:

Name: _____ **DOB:** / / **Subscriber ID:** _____

Primary Language: _____ **Address:** _____

Phone: _____ **Apt:** _____

Baby's DOB: / / **City/State/ZIP:** _____

IMPORTANT: address must be **COMPLETE** and **ACCURATE**!

Email (REQUIRED): _____ **Nipple Diameter/ Flange Size (if known):** _____

Emergency Contact Name: _____ **Emergency Contact Phone:** _____

☑ **Blood Pressure Monitor**
Automatic Blood Pressure Monitor (A4670) and lactation support services [ICD-10: Z39.1, P92.5 CPT: S9443* Place: 12]

Diagnosis (ICD-10): ◯ Hypertension (I10)
◯ Gestational hypertension (O13) ◯ Preeclampsia (O14)
◯ Other: _____

Arm Size: ◯ Standard (8.5"-16.5") ◯ XL (16.5"-22")

☐ **Electric Breast Pump**
Package includes manual breast pump (E0602), milk storage bags refilled as needed (A4287), breast pump replacement parts refilled as needed**, and lactation support services (S9443*) [ICD-10: Z39.1 CPT: E0603, E0602, A4287, S9443* Place: 12]

☐ **IMPORTANT: Check here if pump will be from Lactation Department inventory**

☐ **Hospital Grade Breast Pump For RENT**
Package includes single user breast pump (E0603), manual breast pump (E0602), milk storage bags refilled as needed (A4287), breast pump replacement parts refilled as needed**, and lactation support services (S9443*) [ICD-10: Z39.1 CPT: E0604, E0603, E0602, A4287, S9443* Place: 12 Modifier: RR]

☐ **Manual Breast Pump**
Package includes milk storage bags refilled as needed (A4287), and lactation support services (S9443*) [ICD-10: Z39.1 CPT: E0602, S9443* Place: 12]

☐ **C-Section Bandage System**
[ICD-10: O90.0 CPT: A6212, A6245, S9443* Place: 12]

☐ **Lactation Support Services**
[ICD-10: Z39.1, P92.5 CPT: S9443* Place: 12]
Parent / Child (circle one)
Prenatal / Postpartum (circle one)
Notes/Comments: _____
(eg latching, pumping, low supply, preemie, tether, etc)

☐ **Bili Blanket Rental - home phototherapy**
[ICD-10: P59.9 CPT: E0202, S9443* Place: 12 Modifier: KR]

☐ **Milk Storage Bags - refill as needed**
[ICD-10: Z39.1 CPT: A4287, S9443* Place: 12]

☐ **Breast Pump Replacement Parts - refill as needed**
[ICD-10: Z39.1 CPT: A4281, A4282, A4283, A4284, A4285, A4286, A4288, S9443* Place: 12]

☐ **Lumbar Support Pro:**
Pregnancy back brace, abdominal binder & pelvic floor support
[ICD-10: M54.59, M54.30 CPT: L0642, S9443* Place: 12]

Size:
◯ S (26-33") ◯ M (32-40") ◯ L (39-48") ◯ XL (47-56")

☐ **Maternity Compression Socks for Daily Use, Both Legs**
[ICD-10: O22.02, O22.03 CPT: A6530, S9443* Place: 12, units: 8, two DOS]

Size (Ankle, Calf):
◯ S (6.5-8.5", 11-16.5") ◯ M (8-10", 12-17.5")
◯ L (9-11.5", 13-19") ◯ XL (11-15", 17-23")

*S9443: Lactation support services will include counseling, education, and breastfeeding equipment and supplies.
**Breast pump replacement parts: A4281, A4282, A4283, A4284, A4285, A4286, A4288

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Date: ____/____/____

To Whom It May Concern,

I am writing to request prior authorization for my patient to obtain a blood pressure monitor (A4670).

- Patient Name: _____
- Patient's Medicaid ID: _____
- Length of Need: 12 months
- Height: _____ Weight: _____

My patient meets all criteria for medical necessity.

- Complete diagnosis with complicating factors:

  _____
- Last three blood pressure readings:

Date	Reading

- How frequently does the blood pressure need to be monitored?

  twice daily
- What medication(s) is the member on?

  _____
- If ordering an automatic monitor, explain why a manual monitor will not meet the member's needs:

  patient not educated on how to operate a manual blood pressure cuff
- Additional information that will assist in determining **medical necessity** for this request?

  _____

Sincerely,

Provider Signature:

_____

Provider Name: _____

NPI: _____