



# Prior Authorization Request (PAR) for C-Section Bandage System (A6212, A6245)

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: \_\_\_\_\_

<input type="checkbox"/> <b>C-Section Bandage System</b> [ICD-10: O90.0 CPT: A6212, A6245, S9443* Place: 12]	<input type="checkbox"/> <b>Milk Storage Bags - refill as needed</b> [ICD-10: Z39.1 CPT: A4287, S9443* Place: 12]
<input type="checkbox"/> <b>Electric Breast Pump</b> 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] <input type="checkbox"/> <b>IMPORTANT: Check here if pump will be from Lactation Department inventory</b>	<input type="checkbox"/> <b>Breast Pump Replacement Parts - refill as needed</b> [ICD-10: Z39.1 CPT: A4281, A4282, A4283, A4284, A4285, A4286, A4288, S9443* Place: 12]
<input type="checkbox"/> <b>Hospital Grade Breast Pump For RENT</b> 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]	<input type="checkbox"/> <b>Lumbar Support Pro:</b> Pregnancy back brace, abdominal binder & pelvic floor support [ICD-10: M54.59, M54.30 CPT: L0642, S9443* Place: 12] <b>Size:</b> <input type="radio"/> S (26-33") <input type="radio"/> M (32-40") <input type="radio"/> L (39-48") <input type="radio"/> XL (47-56")
<input type="checkbox"/> <b>Manual Breast Pump</b> Package includes milk storage bags refilled as needed (A4287), and lactation support services (S9443*) [ICD-10: Z39.1 CPT: E0602, S9443* Place: 12]	<input type="checkbox"/> <b>Maternity Compression Socks</b> [ICD-10: O22.02, O22.03 CPT: A6530, S9443* Place: 12] <b>Size (Ankle, Calf):</b> <input type="radio"/> S (6.5-8.5", 11-16.5") <input type="radio"/> M (8-10", 12-17.5") <input type="radio"/> L (9-11.5", 13-19") <input type="radio"/> XL (11-15", 17-23")
<input type="checkbox"/> <b>Lactation Support Services</b> [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)	<input type="checkbox"/> <b>Blood Pressure Monitor</b> Automatic Blood Pressure Monitor (A4670) and lactation support services [ICD-10: Z39.1, P92.5 CPT: S9443* Place: 12] <b>Diagnosis (ICD-10):</b> <input type="radio"/> Hypertension (I10) <input type="radio"/> Gestational hypertension (O13) <input type="radio"/> Preeclampsia (O14) <input type="radio"/> Other: _____
<input type="checkbox"/> <b>Bili Blanket Rental - home phototherapy</b> [ICD-10: P59.9 CPT: E0202, S9443* Place: 12 Modifier: KR]	<b>Arm Size:</b> <input type="radio"/> Standard (8.5"-16.5") <input type="radio"/> XL (16.5"-22")

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

(877) 593-2454

orders@biliblanketbaby.com

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**Prior Authorization Request (PAR) for  
C-Section Bandage System (A6212, A6245) - Page 2**

Date: \_\_\_\_\_

To Whom It May Concern,

I am writing to request prior authorization for my patient to obtain wound closure therapy with a C-Section Bandage System (A6212, A6245).

- Patient Name: \_\_\_\_\_
- Patient's Medicaid ID: \_\_\_\_\_
- Length of Need: \_\_\_\_\_

My patient meets all criteria for medical necessity.

1. Describe wound and include: location, stage, size, depth, any tunneling, etc.

\_\_\_\_\_

2. Describe previous wound treatment, if any.

\_\_\_\_\_

3. Is the member's wound free of necrotic infection?

Yes  No

If the wound has recently been debrided, identify the type and date of debridement:

Surgical - Date: \_\_\_\_\_  Chemical - Date: \_\_\_\_\_

Physical - Date: \_\_\_\_\_  Autolytic - Date: \_\_\_\_\_

4. Will the member's overall health status, including nutritional status, affect wound healing?

Yes  No

5. Supply any additional information that will assist us in determining medical necessity for this request:

\_\_\_\_\_

Sincerely,

Provider Signature:

\_\_\_\_\_

Provider Name: \_\_\_\_\_

NPI: \_\_\_\_\_