

OVHA CLINICAL UNIT

**OFFICE OF VERMONT
HEALTH ACCESS**
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VERMONT MEDICAID PRE-PROCEDURE REQUEST

Date of Request: _____

Date, if Procedure has been scheduled: _____ N/A: Procedure has not been scheduled

Procedure is: Elective Urgent Emergent (Does not require prior authorization).

Setting where procedure will be performed: Hospital Outpatient Hospital Inpatient

Please check if attachments are included:

Patient Name: (last) _____ (first) _____

Medicaid Number: _____ Date of birth: _____ Gender: M F (please circle)

Provider Information

Requesting Provider Name: _____ Vermont Medicaid Provider Number: _____

Requesting Provider NPI: _____ Taxonomy: _____

Provider Address: _____

Office Contact Person: _____ Telephone Number: _____ Fax: _____

Facility Information

Facility Name: _____ Vermont Medicaid Provider Number: _____

Facility NPI: _____ Taxonomy: _____

Facility Address: _____

Office Contact Person: _____ Telephone Number: _____ Fax: _____

Procedure Request(s)

Procedure Requested:

1. Name of Procedure: _____ CPT Code: _____ Diagnosis: _____ ICD-9 Code: _____

2. Name of Procedure: _____ CPT Code: _____ Diagnosis: _____ ICD-9 Code: _____

3. Name of Procedure: _____ CPT Code: _____ Diagnosis: _____ ICD-9 Code: _____

Patient Medicaid Number: _____

Medical Information – All Procedures

Provide convincing information to justify each procedure on page 1.

Have any of the above requested procedures been done previously for the same problem or same condition?

No Yes If yes, when: Month _____ Year _____ Specify results or attach reports of previous test results.

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: _____

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: _____

Gastroplasty

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 ha 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: _____

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