

## Idaho Medicaid Negative Pressure Wound Therapy (NPWT) Prior Authorization Form

Medicaid Provider Information			
Provider Name:	Provider Number:		
Provider Address:	City:	State:	Zip Code:
Contact:	Phone:	Fax:	
Medicaid Participant Information			
Last Name:	First Name:	Initial:	
Medicaid ID Number:	Date of Birth:		
Phone Number:	Healthy Connections: Y N Referral Number:		
Physician Information			
Name and Address:			
Phone Number:			
Diagnosis:	ICD-9		
HCPCS Code: E2402	Monthly Rental	Start Date:	End Date:
Urgent:	Yes	No	Monthly Rental Price:
Supplies: A6550 (dressings) limited to 15 per month without prior authorization. A7000 (canisters) limited to 10 per month without prior authorization.			

### Initial Request – Required Documentation:

- \_\_\_ Current signed Physician Order with diagnosis, date, length of need.
- \_\_\_ Current description of wound including occurrence date, location, type/stage, precise measurements, quantity of exudates, presence of granulation and necrotic tissue, presence of tunneling if applicable.
- \_\_\_ Documentation of current wound management. Documentation of previous treatment regimen including dressing type, and frequency of change, if applicable.
- \_\_\_ Measures being addressed such as debridement, nutritional concerns, support surfaces, positioning, incontinence control, diabetic management, etc.
- \_\_\_ Current History & Physical or physician Progress Notes.
- \_\_\_ Examples of additional records which may be submitted to support the need for NPWT: Recent hospital records, operative reports, wound clinic progress notes, antimicrobial therapy records, and/or albumin lab values.

**Extended Authorization Request - Required Documentation**

\_\_\_ Recent assessment by treating licensed health care professional including updated wound measurements, healing progress, and other wound characteristics. Submit recent physician Progress Notes or Wound Clinic Notes, if available.

\_\_\_ Therapy exceeding four months, requires additional supporting documentation explaining the special circumstances for extended use.

**Note: Medicaid payment is for actual days of service only.**

(Department Use Only) Do not Write in Area Below				
Received Date:	Eligibility:	LTC:	TPOI:	Urgent:
Authorized: Yes No	Denied: Yes No	PA Number:		
Nurse Reviewer:			Date:	
Keyed By:			Date:	

Idaho Department of Health and Welfare  
Division of Medicaid  
PO Box 83720  
Boise, ID 83720-0036  
Phone: (866) 205-7403  
**Fax:** (800) 352-6022