Topical Negative Pressure Therapy for Wounds Device Coverage Extension Request Form

Member Name:	Member ID:
Requesting Physician:	Contact Name:
Phone Number: ( )	Fax Number: ( )

The member named above has requested continued coverage for Topical Negative Pressure Therapy for Wounds Device

BCBSNC will provide continued coverage for Topical Negative Pressure Therapy for Wounds Device when the criteria shown below are met in accordance with BCBSNC Topical Negative Pressure Therapy for Wounds Medical Policy
http://www.bcbsnc.com/services/medical-policy/pdf/topicalnegativepressuretherapyfor wounds.pdf

RENEWAL (EXTENSION) APPROVAL:

	Yes	No
Does the patient continue to require and receive on-going wound care performed or supervised by a licensed health care provider?	☐	☐
o Is there at least biweekly documentation of quantitative wound characteristics (length, width, and depth or surface area and depth)?	☐	☐
o Do the recorded wound measurements demonstrate that progressive wound healing has occurred over the previous authorization period?	☐	☐
o Does the wound depth continue to be greater than 0.5cm?	☐	☐

Date of most recent wound measurements: _____

Length: _____ Width:_____ Depth:_____

If the above BCBSNC Medical Policy criteria are met, coverage for a Topical Negative Pressure for Wounds Device will be approved for an additional period of 14 days.

BCBSNC does not provide coverage for a Topical Negative Pressure Therapy for Wounds Device:
♦ When the above criteria are not met.

By my signature below, I certify that the information on this form accurately reflects the content of my medical records. I agree to submit medical records to BCBSNC for review upon request.
Physician signature: _____ Date: _____

***Fax completed form to* 1-800-228-0838**