

**Negative Pressure Wound Therapy (NPWT) Pump Rental  
Prior Authorization (PA) Request Form**

**(Incomplete Form May Delay Processing)**

Provider Information		Member Information
Ordering Physician Name:	NPI #:	Member Name:
Office Phone#: Office Fax#:	Contact Name:	Member ID #:
Vendor Name:	NPI #:	Member's Date of Birth:
Vendor Phone #: Vendor Fax #:	Contact Name:	Member's Phone #:

ICD-10 Code(s):

**Please answer questions below**

**HCPCS code(s) (REQUIRED):** \_\_\_\_\_

**If this is the initial rental from an outpatient setting, please provide the following information:**

- What is the start date of the rental?    /    /
- Do any of the following conditions exist in the area of the wound?.....  Yes  No
  - Osteomyelitis within the area of the wound that is not at the same time being treated with intent to cure
  - Cancer present in the wound
  - An open fistula to an organ or body cavity within the area of the wound
- What type of wound does the member have?
  - Chronic Stage III pressure ulcer
  - Chronic Stage IV pressure ulcer
  - Neuropathic ulcer
  - Venous or arterial insufficiency ulcer
  - Chronic ulcer of mixed etiology
- Please list all wound care measures tried and failed. \_\_\_\_\_  
\_\_\_\_\_
- What are the current wound measurements (determined by a licensed medical professional) to include length, width, and depth (l x w x d)? \_\_\_\_\_
- If present, was necrotic tissue debrided?.....  Yes  No  NA
- Has the member been evaluated for adequate nutritional status? .....  Yes  No
- Were any identified nutritional conditions addressed? .....  Yes  No  NA

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9. For Stage III and IV pressure ulcers:

- a. Has the member been appropriately turned and positioned? .....  Yes  No
- b. Has the member used a Group 2 or 3 support surface for pressure ulcers on the posterior trunk or pelvis?  
.....  Yes  No
- c. Has the member's moisture and incontinence been appropriately managed?.....  Yes  No  N/A

10. For neuropathic ulcers:

- a. Has the member been on a comprehensive diabetic management program?.....  Yes  No
- b. Has reduction in pressure on a foot ulcer been accomplished with appropriate modalities?.....  Yes  No

11. For venous insufficiency ulcers:

- a. Have compression bandages and/or garments been consistently applied? .....  Yes  No
- b. Has leg elevation and ambulation been encouraged? .....  Yes  No

**Was the pump placed on an ulcer/wound encountered during an inpatient setting?** .....  Yes  No  N/A

- 1. If yes, please submit inpatient medical records relevant to the wound and wound treatments.
- 2. What date was the pump placed?   /  /   -   /  /

**If this request is for continued coverage/rental, please provide the following information:**

- 1. Which month's rental is being requested?.....  2nd  3rd  4th  Beyond 4th
- 2. On a regular basis:
  - a. Has a medical professional directly assessed the wound(s) being treated with the pump? .....  Yes  No
  - b. Has a medical professional supervised or directly performed the pump dressing changes? .....  Yes  No
- 3. On at least a monthly basis, has a medical professional documented changes in the ulcer's dimensions and characteristics? .....  Yes  No
- 4. What are the current wound measurements (l x w x d)?\_\_\_\_\_

I certify that I have appropriate authority to request an organization determination for the item(s) indicated on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information.

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

**Please Return Completed Form to:**

Fax 1-336-794-1556

For questions, please call Care Management at 1-888-296-9790.

Blue Cross and Blue Shield of North Carolina is an HMO/PPO plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.