REVIEW REQUEST FOR

Custom – made Knee Braces

Anthem UM Services, Inc.

Provider Data Collection Tool Based on Clinical Guideline CG-OR-PR 03

Policy Last Review Date: 05/13/10	Policy Effective Date: 07/07/10	Provider Tool Effective Date: 8/10/09

Individual's Name:	Date of Birth:
Insurance Identification Number/HCID:	Individual's Phone Number:
Ordering Provider Name & Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:
Rendering Provider Name & Specialty: Integra Partners	Provider ID Number: 12DME0967NY01
Office Address: 40 Exchange Place Suite 1705 New York, NY 10005	
Office Phone Number: 718-369-0012	Office Fax Number: 718-228-9423

Date/Date Range of Service:	Place of Service: ☐ Home ☐ Inpatient ☐ Outpatient ☐ Other: ________________
Service Requested (CPT/HCPCS if known):	
Diagnosis (ICD-9) if known):	

Please check all that apply to the individual:

☐ Request is for a custom-made (custom fabricated, custom molded) **unloader** knee brace as an alternative to a prefabricated (custom – fitted) knee brace

☐ Request is for an individual with unicompartmental osteoarthritis with or without valgus/varus deformity (check all that apply)

- ☐ Individual is a candidate for high tibial osteotomy or total knee arthroplasty (replacement) and may elect non-surgical treatment
- ☐ To predict the success of high tibial osteotomy versus total knee arthroplasty
- ☐ Individual has severe patellofemoral arthrosis in conjunction with medial or lateral compartment arthrosis.

☐ Other: ______

☐ Request is for a custom–made (custom fabricated, custom molded) **functional** knee brace as an alternative to a prefabricated (custom – fitted) knee brace

- ☐ Request is for an individual with an abnormal limb contour (disproportionate size of thigh and calf)
- ☐ Request is for an individual with a knee deformity that interferes with fitting (valgus or varus limb)
- ☐ Request is for an individual with minimal muscle mass upon which to suspend an orthosis.

☐ Other: ______

This request is being submitted:

☐ Pre-Claim

☐ Post–Claim. If checked, please attach the claim or indicate the claim number ________________

I attest the information provided is true and accurate to the best of my knowledge. I understand that Anthem may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

____ ________________

Name and Title of Provider or Provider Representative Completing Form and Attestation (Please Print)* Date

***The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted**

Anthem UM Services, Inc., a separate company, is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.