healthfirst
Health Insurance for New Yorkers

Podiatry and Peripheral Vascular Disease Prior Authorization Request

Please fax to Healthfirst at **1-646-313-4603**

Date: # of Pages:

Instructions

1. Use this form when requesting prior authorization of Podiatry and Peripheral Vascular Disease services for Healthfirst members.
2. Please complete and fax this request form along with all supporting clinical documentation to Healthfirst at **1-646-313-4603**.
3. For help completing this form, please contact Healthfirst Provider Services at 1-888-801-1660.
4. For a faster response, please use the Online Authorization tool on the Healthfirst Provider Portal at **hfproviderportal.org**. To create an account, select Create your account, or contact your Healthfirst Network Account Manager.
5. Please PRINT, in black ink, one character per box for ALL requested information and completely fill in each circle for selection where applicable.

NOTE: The information transmitted is intended only for the person or entity to which it is addressed and may contain CONFIDENTIAL material.

If you receive this material/information in error, please contact the sender and delete or destroy the material/information.

Patient Information

Healthfirst Member ID Number		OR Medicaid Member ID Number
First Name	**Last Name**	**Date of Birth**

Provider Information

Provider or Facility Name	National Provider Identifier (NPI)	Tax ID Number
Address		
City	**State**	**Zip**
Phone Number	**Fax Number**	

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Request Information

Diagnosis Code (ICD-10)	Request Type	Anticipated Date of Service
	◯ Inpatient ◯ Outpatient	

Place of Service

◯ Office ◯ Ambulatory Surgical Center ◯ Outpatient Hospital

Are you treating:

◯ Right Lower Extremity ◯ Left Lower Extremity ◯ Both

CPT Code(s):

Other CPT Codes Not Listed Above:

Facility Name for Surgery/Procedure(s) *(if applicable)*:

City	State	Facility Tax ID Number

Ankle-Brachial Index

ABI Date ☐ Right ☐ Left

Pelvic/Lower Extremity Vascular Imaging Studies Performed *(Attach ALL reports for any of the below)*

☐ Vascular Ultrasound/Duplex ☐ CT Angiography ☐ MR Angiography

☐ Digital Subtraction Angiography ☐ Ankle-Brachial Index/Pulse Volume Recording

Current or Prior Medical Treatment for These Conditions *(Attach supporting documentation AND reports)*

☐ Smoking Cessation ☐ Dietary Changes ☐ Pharmacotherapy ☐ Exercise

☐ Surgery *(include all lower-extremity vascular interventions with laterality and date(s) of procedure)*

☐ Other

Podiatry and Peripheral Vascular Disease Prior Authorization Request

Lower-Extremity Signs/Symptoms *(Check all that apply)*

Edema

◯ Unilateral ◯ Bilateral

AND

◯ Non-Pitting ◯ Pitting: ◯ 1+ ◯ 2+ ◯ 3+ ◯ 4+

Claudication

◯ Mild ◯ Moderate ◯ Severe ◯ Intermittent ◯ Disabling

Discoloration

◯ Red ◯ Blue ◯ Reddish-Blue ◯ Bronze ◯ Greenish ◯ Black ◯ Darkening

Hair Loss

◯ Mild ◯ Moderate ◯ Severe

Skin

◯ Glossy ◯ Leathery ◯ Itchy ◯ Dry ◯ Thick

Venous Reflux

◯ Mild ◯ Moderate ◯ Severe

AND

◯ Treated ◯ Untreated

AND

◯ Varicose Veins Present ◯ No Varicose Veins

Peripheral Pulses

Posterior Tibial: ◯ 0 ◯ 1+ ◯ 2+ ◯ 3+ ◯ 4+

Dorsalis Pedis: ◯ 0 ◯ 1+ ◯ 2+ ◯ 3+ ◯ 4+

Temperature

◯ Warm ◯ Cool ◯ Cold

Gangrene

◯ Dry ◯ Wet ◯ Gas

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Lower-Extremity Signs/Symptoms *(Check all that apply)*

Ambulation

◯ Independent ◯ Dependent with Supervision ◯ Dependent with Assistance ◯ Nonfunctional

Wound

◯ Sore ◯ Red ◯ Swollen

AND

◯ Healing ◯ Non-Healing

Numbness

◯ Mild ◯ Moderate ◯ Severe

Muscle Strength

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

AND

◯ Weakness ◯ Tiredness ◯ Heaviness ◯ Achiness

Pain

Location: ◯ Buttock ◯ Thigh ◯ Calf ◯ Foot

AND

Description: ◯ Mild ◯ Moderate ◯ Severe

AND

◯ Chronic ◯ Acute

AND

◯ Diffuse ◯ Focal

AND

◯ Rest ◯ Day ◯ Night

AND

◯ Improves with Elevation ◯ Improves with Dependency ◯ Functional Impairment

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Lower-Extremity Signs/Symptoms *(Check all that apply)*

Ulcer

Location: ☐ Proximal Leg ☐ Distal Leg ☐ Ankle ☐ Foot

AND

Description: ◯ Superficial ◯ Deep ◯ Stasis ◯ Pressure ◯ Ischemic ◯ Exudative
◯ Recurrent ◯ Painful ◯ Foul ◯ Dirty ◯ Healing ◯ Non-Healing

Other Medical Condition(s)

☐ Congestive Heart Failure ☐ Chronic Obstructive Pulmonary Disease ☐ Amputation(s)
☐ Stroke ☐ Osteoarthritis ☐ Depression ☐ Obesity ☐ Herniated Disc ☐ Spinal Canal Stenosis
☐ Degenerative Spinal Disease

Please attach to this fax clinical notes, including the initial evaluation, all follow-up notes dated within the last three months with patient's symptoms, exam findings, all prior conservative management, documentation of surgical plan, and related imaging reports dated within the past 12 months.

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