Continuous Passive Motion

Prior Authorization Form

Quality and Utilization Improvement Dept. Fax: (952) 853-8714 Phone: 1 (888) 467-0774

To be completed by a Health Practitioner (MD, NP, PA etc), not Vendor or Member.
Please print the answer to all of the following questions. This information is required in order to determine whether coverage criteria are met.

Member Name:	**Date of Birth:** ___/___/_____	**Member #:**
Form Completed by and date:	**Phone:** ( ) ____-_____	**Fax :** ( ) ____-_____

Vendor: _____Phone: _____ Fax_____

Practitioner ordering: _____NPI:_____

Clinic Phone ( ) _____-_____ Clinic Fax ( ) _____-_____

1. **Diagnosis: _____ IDC9/10:_____**
2. **Recent Surgery? □ Yes Date_____ □ No**
3. **Procedure_____**
4. **Length of need: □ 42 days □ Other**
5. **Rationale if request is for longer than 42 days**

   _____
   _____
   _____
   _____

6. **Does member currently reside in a skilled nursing facility / transitional care unit?**
   □ Yes □ No

Attach any additional clinical information from member's medical record.

I confirm that the information above is correct.

Physician or Treating Practitioner Signature:	**Date:**