

Foundation Authorization Request for DEXA Scan

Fax Completed Form to 707-442-2047 or Mail to the Foundation, P.O. Box 1395, Eureka, CA 95502

Incomplete request forms will be returned without being processed.

Notification will be sent to the member, the requesting provider, the member's PCP (if different than the requesting) and the proposed provider.

Foundation Authorization Tracking Number:

MEMBER INFORMATION

Patient Name: _____ Gender: M / F Date of Birth: _____

Patient's Address _____ () _____

Street City Zip Phone

Health Plan: HMO: Anthem Blue Cross CaliforniaCare HMO/POS - Blue Shield Cal PERS HMO

PPO: Blue Lake Rancheria - Trinidad Rancheria

Subscriber Name: _____ Group #: _____

Member's Primary Care Provider: _____ Subscriber #: _____

Requested CPT Code: (77080 or other) _____ Quantity _____ ICD9 Code: _____

REQUESTING PROVIDER INFORMATION

PROPOSED PROVIDER & FACILITY INFORMATION

Name: _____ Name: _____

Address: _____ Address: _____

City, State, ZIP: _____ City, State, ZIP: _____

Phone: _____ Fax: _____ Phone: _____ Fax: _____

Contact Name: _____ Tax ID # (Out of Area Providers only): _____

Today's Date: _____ Place of Service: _____

REQUEST FOR DEXA SCAN – MEDICAL NECESSITY

1. Is this a Repeat Request for a DEXA Scan? NO YES **Current WEIGHT:** _____
If YES, Repeat Scan: Date of last Scan: _____ Results _____ (or fax copy of the report)

2. Date of last menstrual period: _____

3. Taking estrogens? NO YES

4. Currently taking or a history of taking medications to treat osteoporosis? NO YES

If YES, Medication _____ Date Prescribed: _____ Date Stopped: _____

5. Currently taking or a history of taking Prednisone or other medications known to cause bone loss? NO YES

If YES, Medication _____ Date Prescribed: _____ Date Stopped: _____

6. Known or suspected to have a condition that may underlie osteoporosis, such as hyperparathyroidism, chronic kidney or liver disease, malabsorption syndromes, or inflammatory bowel disease? NO YES (please list) _____

7. Unusual fractures, loss of height or vertebral abnormalities pointing to bone loss on x-ray? NO YES

If YES, please describe _____

- Approved authorizations are effective from the date they are received and expire three (3) months from the effective date and are based on the member's eligibility at the time the authorization is reviewed. Providers must verify member eligibility within 5 days of the date of service to ensure coverage..
- Claims for services rendered without required prior authorization may be denied reimbursement. Claims for the above services must be submitted for the same service, CPT code and provider group (tax id #) as those approved or documentation must be submitted to explain the medical necessity of alternative and/or additional services.
- The requesting physician or the member may submit authorization appeals to the Foundation Medical Management Department.
- This is confidential and privileged information protected by California Civil Code § 43.97, Health & Safety Code §1370, and California Evidence Code §1157.

CONFIDENTIAL INFORMATION

This facsimile is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is strictly prohibited. If you have received this message by error, please notify us immediately and destroy the related message. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without appropriate patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law.