

NEIGHBORHOOD HEALTH PARTNERSHIP

PRE-CERTIFICATION FORM

FOR: External Insulin Pump and Supplies

Fax Requests to 800-731-6984

Please be advised, failure to comply with Utilization Management certification protocol will result in non-payment of your claim.

To avoid any delay of this review, please submit all relevant documentation with this form.

**** Please include all pertinent clinical information and laboratory results ****

PATIENT INFORMATION	REQUESTING PROVIDER INFORMATION
Patient Name: _____ ID Number: _____ Patient DOB: ____/____/____	Provider Name: _____ Provider ID: _____ Phone: _____ Fax: _____ Contact Name: _____ <input type="checkbox"/> PCP Request <input type="checkbox"/> Specialist Request
PROCEDURE INFORMATION	CHOOSE ONE PROVIDER FOR THE PUMP <u>AND</u> SUPPLIES
Primary Diagnosis: _____ Secondary Diagnosis: _____ Diagnosis Code: _____ <p style="text-align: center;">Please Check:</p> New Insulin Pump <input type="checkbox"/> Pediatric Pump Model <input type="checkbox"/> Replacement Pump <input type="checkbox"/> Reason: _____	<input type="checkbox"/> Minimed Distribution Group- 800-933-3322 <input type="checkbox"/> Animas Diabetes Care LLC- 877-937-7867 <input type="checkbox"/> Disetronic Medical System- 800-280-7801 <input type="checkbox"/> Smiths Medical MD- 800-826-9703
CRITERIA CHECKOFF LIST	
1. Has the patient completed a comprehensive diabetes education program? 2. Has the patient been on a program of multiple daily injections of insulin (at least 3 injections per day)? 3. Along with the three daily injections, has the patient had frequent self adjustments of insulin dose for at least 6 months prior to initiation of the insulin pump? 4. Does the patient have documented frequency of glucose self-testing an average of at least 4 times per day During the 2 month prior to initiation of the insulin pump? 5. Does the patient have a Glycosylated hemoglobin Level (HbA1C) greater than 7%?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Please include with clinical information any wide fluctuations in blood sugars before mealtime, dawn phenomenon with fasting blood sugars frequently exceeding 200mg/dl and any history of severe glycemc excursions. (Include lab results with request).</p>	

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