



HEALTHCARE COOPERATIVE

Common Ground Healthcare Cooperative
PO Box 1630
Brookfield, WI 53008-1630
T: 877.825.9293 | F: 715.221.9749

Skin Substitute

Prior Authorization Request

Date \_\_\_\_\_

Member information, Provider information, Procedure information form with fields for member name, SMID, date of birth, provider name, telephone number, fax number, place of service, facility address, contact person, scheduled date, requested service, procedure code, diagnosis, and diagnosis code.

Answer all of the following questions.

What type of skin substitute will be used \_\_\_\_\_

Where will this be placed on the member's body \_\_\_\_\_

Does the member have any comorbidity conditions such as: [ ] Diabetes [ ] Burns

What past treatments have failed for this member \_\_\_\_\_

Is this the member's initial treatment: [ ] Yes [ ] No

By signing this form, the provider attests that the above information is accurate and documented in the medical record. CGHC may, at its discretion, request medical records to make a final coverage determination.

Provider signature \_\_\_\_\_

Date \_\_\_\_\_

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Mail or fax form to: Common Ground Healthcare Cooperative, PO Box 1630, Brookfield, WI 53008-1630, T: 877.825.9293 | F: 715.221.9749

If you have any questions, please contact Customer Service at 1.877.514.2442