HUSKY Health Program Skin Substitutes
Prior Authorization Request Form
Phone: 1.800.440.5071

THIS FORM IS TO BE COMPLETED BY THE ORDERING PROVIDER AND FAXED WITH CLINICAL DOCUMENTATION TO 203.265.3994.

Member Information			
Member ID Number:		Member Name (Last, First):	
DOB:		Sex:	
Address:		City, State, Zip:	
Ordering/Treating Provider Information			
Medicaid Billing Number:		Referring Provider Name (Last, First):	
Phone Number:	Fax Number:	NPI Number:	
Address:		City, State, Zip:	
Billing Provider/Provider Group Information			
Medicaid Billing Number:		Billing Provider/Provider Group Name:	
Phone Number:	Fax Number:	NPI Number:	
Address:		City, State, Zip:	
Authorization Information			
Practice location where service will be provided:		To and from dates of service:	
Diagnosis:		Diagnosis Code(s):	☐ Diabetic Foot Ulcer (DFU) ☐ Venous Leg Ulcer (VLU) ☐ Other: _____
Type/name of skin substitute:		HCPCS code:	Total # units (sq. cm.) requested:
Approximate wound size in sq. cm.:		Anticipated number of applications:	Anticipated number of sq. cm. for each application:
Clinical Information			
Please attach clinical information from the medical record supporting medical necessity as outlined in the *Clinical Guideline* section of the *HUSKY Health Skin Substitutes Policy*.			
Certification Statement: This is to certify that the requested item is medically indicated and is reasonable and necessary for the treatment of this patient and that a prescribing practitioner signed order is on file. This form and any statement on my letterhead attached hereto has been completed by me or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil and criminal liability.			
Provider Signature:			Date: