SecurityHealth Plan℠
Promises kept, plain and simple.

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 or 715.221.9555
TTY: 1.877.727.2232 or 715.221.9898

Electrical Stimulation and Electromagnetic Therapy

Prior Authorization Request

Date ______________________________

Member information		
Member name (print)	MHN	Date of birth (month/day/year)
Provider information		
Provider name (print)	Telephone number	Fax number

Place of service: ☐ Ambulatory Surgery Center ☐ Hospital outpatient ☐ Hospital inpatient
☐ Provider's office ☐ Other ____

Facility where services will be provided (include address if the provider provides services at more than one practice location)

Procedure information		
Scheduled date of service (month/day/year)	Requested service/procedure	Procedure code(s)
Diagnosis	Diagnosis code(s)	

Answer all of the following questions.

Does the member have one of the following: chronic (not healed within 30 days of occurrence) Stage III or IV pressure ulcers, arterial ulcers, diabetic ulcers or venous stasis ulcers . . . . ☐ Yes ☐ No

Has appropriate standard wound therapy* been tried for at least 30 days (30-day period can begin while the wound is acute). . . . . ☐ Yes ☐ No

Are there measurable signs of healing (decrease in wound size, either surface area or volume, decrease in exudates, and decrease in amount of necrotic tissue) . . . . ☐ Yes ☐ No

Is this service being performed by a physician, physical therapist or incident to a physician service . . . ☐ Yes ☐ No

* *Standard wound care = optimization of nutritional status; debridement by any means to remove devitalized tissue; maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings; and necessary treatment to resolve any infection that may be present. Standard wound care based on specific type of wound = frequent repositioning of a patient with pressure ulcers (usually every 2 hours); off-loading of pressure and good glucose control for diabetic ulcers; establishment of adequate circulation for arterial ulcers; and the use of a compression system for patients with venous ulcers.*

By signing this form, the provider attests that the above information is accurate and documented in the medical record. Security Health Plan 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: Security Health Plan
Health Services Department
PO Box 8000
Marshfield, WI 54449-8000
Fax 715-221-6616

Marshfield Clinic providers route to:
Health Services Department
Routing location, SHP

If you have any questions, please contact Customer Service at 1.800.472.2363.

831-00057-09 (10/13) © 2013 Security Health Plan of Wisconsin, Inc. Expires 9/2014