SecurityHealth Plan℠
Promises kept, plain and simple.

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

1.800.472.2363 | 715.221.9555
TTY: 1.877.727.2232 | 715.221.9898

Lipectomy

Prior Authorization Request

Date _____

Member information		
Member name (print)	SMID	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.

The requested service is: ☐ Suction-assisted lipectomy ☐ Lipectomy

The medical records documents that the excess skin folds cause a chronic intertrigo that is refractory to at least 3 months of appropriate medical therapy or consistently recurs over 3 months while receiving appropriate medical therapy ..... ☐ Yes ☐ No

There is a presence of significant functional deficit that prohibits or profoundly impairs the ability to perform activities of daily living due to a significant physical deformity or disfigurement resulting from excess skin folds, and surgery is expected to restore or greatly improve the functional deficit ..... ☐ Yes ☐ No

Documentation that support medical necessity for procedure with signs and symptoms of:

- Is the member having pain ..... ☐ Yes ☐ No
- Has the member had massive weight loss or gain ..... ☐ Yes ☐ No
- Has the member had recurrent infections ..... ☐ Yes ☐ No
- Does the member have functional impairment. ..... ☐ Yes ☐ No

Is this performed to solely enhance the member's appearance ..... ☐ Yes ☐ No

Clear supporting evidence of physical exam and documented by photographs for medical necessity

_____

If yes to any of these questions above, please submit medical documentation.

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.

