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: 711

MAZE Procedure

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)		
Contact person name (print)	Telephone number	Fax number
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.

Is the MAZE procedure performed with cardiopulmonary bypass. . . . . ☐ Yes ☐ No

- Member has failed medical management . . . . . ☐ Yes ☐ No
- Member cannot tolerate the side effects of drug therapy (adequate documentation of the nature and extent of the intolerance is required) . . . . . ☐ Yes ☐ No
- Member is suffering the hemodynamic consequences of chronic atrial fibrillation/flutter despite adequate attempts at medical management. . . . . ☐ Yes ☐ No
- Member is at high risk for thromboembolism as evidenced by either:
  - A previous episode of thromboembolism when other sources of emboli have been ruled out . . . ☐ Yes ☐ No
  - Documented long-standing atrial fibrillation in members with mitral valve disease undergoing open surgical repair of the mitral valve . . . . . ☐ Yes ☐ No

Is this for minimally invasive, off-pump MAZE procedure (i.e. TOPS or mini MAZE procedure) . . . . . ☐ Yes ☐ No

- Member having procedure done due to atrial fibrillation. . . . . ☐ Yes ☐ No
- Member with symptomatic recurrent episodes of paroxysmal or persisting, atrial fibrillation refractory to the maximal tolerated dose of class IC and/or III AAD and at least one failed electrical pharmacological cardioversion attempt during the preceding 6 months . . . . . ☐ Yes ☐ No
- Member with symptomatic atrial fibrillation who have failed catheter ablation . . . . . ☐ Yes ☐ No

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 1.800.548.1224

