SecurityHealth Plan℠

Promises kept, plain and simple.®

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Technology Assessment Review

Requester		
Address		
City	State	ZIP
Phone		

Device, procedure or treatment for review (include ICD-9 and/or CPT codes if applicable):

1. Alternative treatment available for the condition being treated by the device, procedure or treatment being reviewed. List up to three alternatives.
   - _____
   - _____
   - _____
2. Has the device, procedure or treatment been granted FDA approval ..... ☐ Yes ☐ No ☐ N/A
3. Has the device, procedure or treatment been recognized, in the United States, as acceptable medical practice to treat the illness or injury in question ..... ☐ Yes ☐ No ☐ N/A
4. Is the device, procedure or treatment commonly used on a widespread geographic basis ..... ☐ Yes ☐ No ☐ N/A
5. What are the failure rate and side effects of the device, procedure or treatment being reviewed:
6. Will the device, procedure or treatment supplement another method of treating the illness or injury ..... ☐ Yes ☐ No ☐ N/A

   If so, what: _____
7. Does Medicare recognize this device, procedure or treatment for reimbursement ..... ☐ Yes ☐ No ☐ N/A
8. Under what circumstances would you recommend use of this device, procedure or treatment:
9. Additional information or comments you would like to share with the committee:

Please include applicable clinical studies or research articles to support the requested item.

Fax information to 715-221-6614.

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