SecurityHealth Plan℠
Promises kept, plain and simple.®

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

1.800.548.1224
TTY: 711

Carpal Tunnel Syndrome – Median Neuropathy – Specialty Consult

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)		
Referring provider name (print)	Telephone number	Fax number
Referring provider's contact person name (print)	Telephone 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 this consult needed due to an acute injury . . . . . ☐ Yes ☐ No

If yes, date (month/day/year) of injury _____ /_____ /_____

If yes, clinical information is not required. Submit form to Security Health Plan for notification.

If factors below are present, expeditious surgical evaluation may be necessary, and a 6-week trial of conservative management would not be required prior to referral to a surgical specialist:

- Weakness of thenar muscles, including weakness of grip or pinch . . . . . ☐ Yes ☐ No
- Thenar muscle atrophy . . . . . ☐ Yes ☐ No
- Impairment of dexterity . . . . . ☐ Yes ☐ No
- 2-point discrimination > 6 mm in median nerve distribution . . . . . ☐ Yes ☐ No
- Prolonged periods of numbness lasting more than a few minutes and occurring several times during any 24-hour period . . . . . ☐ Yes ☐ No
- Constant or nearly constant numbness in the median nerve distribution . . . . . ☐ Yes ☐ No
- Documented symptoms of carpal tunnel syndrome of 6 months or longer. . . . . ☐ Yes ☐ No

If yes to above questions, do not wait for approval. Submit form to Security Health Plan for notification.

In the absence of severe symptoms for which expedited surgical evaluation may be necessary:

Are there findings in the affected wrist/hand/forearm ☐ Yes ☐ No

Is there pain, paresthesia, numbness, or impaired dexterity ☐ Yes ☐ No

Are there continued symptoms or findings after treatment greater than or equal to 6 weeks:

- Wrist splints greater than or equal to 6 weeks ☐ Yes ☐ No
- Activity modification greater than or equal to 6 weeks ☐ Yes ☐ No

Has patient had carpal tunnel surgery within the last year ☐ Yes ☐ No

If yes, date (month/day/year) of surgery _____ /_____ /_____

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.

