

## Core Decompression

### 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: <input type="checkbox"/> Ambulatory Surgery Center <input type="checkbox"/> Hospital outpatient <input type="checkbox"/> Hospital inpatient <input type="checkbox"/> Provider's office <input type="checkbox"/> 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.**

Core decompression treatment of the following indications:

- Is this for treatment of early (pre-collapse stage I and II) avascular necrosis of the femoral head. . .  Yes  No
- Late/Post collapse (stage III or higher; when X-ray changes have occurred) avascular necrosis of the hip . . . . .  Yes  No
- Avascular necrosis of other joints (e.g., ankle, elbow, knee, mandibular condyle, humeral head, distal femur, talus, shoulder). . . . .  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.

<p><b>Mail or fax form to:</b> Security Health Plan                  Health Services Department                  PO Box 8000                  Marshfield, WI 54449-8000                  Fax 715.221.6616</p>	<p><b>Marshfield Clinic providers route to:</b>                  Health Services Department                  Routing location, SHP</p>
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**If you have any questions, please contact Customer Service at 1.800.548.1224**