Humboldt IPA Authorization Request for DEXA Scan

Fax Completed Form to 707-442-2047 or Mail to the IPA, 2662 Harris Street, Eureka, CA 95503
Phone: 707 443-4563; we do not accept authorization requests over the phone.
Incomplete request forms will be returned without being processed.
Notification will be sent to the member, the requesting provider, the member's PCP (if different than the requesting) and the proposed provider.

MEMBER INFORMATION:

Patient Name:_____ Gender: ☐ M / ☐ F Date of Birth:_____

Patient's Address _____ (__) _____
Street City Zip Phone

Health Plan: HMO: ☐ Anthem Blue Cross CaliforniaCare HMO/POS - Blue Shield Cal PERS HMO
PPO: ☐ Blue Lake Rancheria - Trinidad Rancheria - North coast Co-op

Subscriber Name: _____ Group #:_____

Member's Primary Care Provider:_____ Subscriber #:_____

Requested CPT Code: (77080 or other) _____ Quantity _____ ICD10 Code: _____

REQUESTING PROVIDER INFORMATION	PROPOSED PROVIDER & FACILITY INFORMATION
Name:	Name:
Address:	Address:
City, State, ZIP:	City, State, ZIP:
Phone: Fax:	Phone: Fax:
Contact Name:	Tax ID # (Out of Area Providers only):
Today's Date:	Place of Service:

REQUEST FOR DEXA SCAN – MEDICAL NECESSITY

1. Is this a request for a REPEAT DEXA Scan? NO☐ YES☐ Current WEIGHT: _____
   If YES: Date of last Scan: _____ Results _____ **(or fax copy of the report)**

2. Date of last menstrual period: _____

3. Taking estrogens? NO☐ YES☐

4. Currently taking or a history of taking medications to treat osteoporosis? NO☐ YES☐
   If YES, Medication_____ Date Prescribed: _____ Date Stopped: _____

5. Currently taking or a history of taking Prednisone or other medications known to cause bone loss? NO☐ YES☐
   If YES, Medication _____ Date Prescribed: _____ Date Stopped: _____

6. Known or suspected to have a condition that may underlie osteoporosis, such as hyperparathyroidism, chronic kidney or liver disease, malabsorption syndromes, or inflammatory bowel disease? NO YES (please list) _____

7. Unusual fractures, loss of height or vertebral abnormalities pointing to bone loss on x-ray? NO☐ YES☐
   If YES, please describe_____

- Approved authorizations are effective from the date they are received and expire three (3) months from the effective date and are based on the member's eligibility at the time the authorization is reviewed. Providers must verify member eligibility within 5 days of the date of service to ensure coverage..
- Claims for services rendered without required prior authorization may be denied reimbursement. Claims for the above services must be submitted for the same service, CPT code and provider group (tax id #) as those approved or documentation must be submitted to explain the medical necessity of alternative and/or additional services.
- The requesting physician or the member may submit authorization appeals to the IPA Medical Management Department.
- This is confidential and privileged information protected by California Civil Code § 43.97, Health & Safety Code §1370, and California Evidence Code §1157.

Revised 01-2015