Prosthesis Coverage Determination Request Form

Point32Health
Harvard Pilgrim Health Care TUFTS Health Plan

Submit the **completed** form and required documentation for review. We encourage you to complete and submit your request using our secure portals. For details on this and other options, please refer to our How to request prior authorization webpage.

Member name:

Member ID # Date of birth: / /

Diagnosis (*include ICD-9 codes*):

Requesting provider name: NPI #

Address: Phone:

Provider/facility name: NPI #

Address: Phone:

Contact person: Fax:

Description of prosthesis:

HCPCS Code	Modifiers	Number of units

Prognosis:

Clinical information (*please attach all information, e.g., physician Rx, functional status, treatment/progress notes, initial or replacement request, etc.*):

CLEAR FORM