BlueCross BlueShield of North Carolina

Use for Medicare Advantage – including D-SNP

Lumbar Sacral Orthosis (LSO)/Thoracic Lumbar Sacral Orthosis (TLSO) Prior Authorization (PA) Request Form

(Incomplete Form May Delay Processing)

Provider Information		Member Information
Ordering Physician Name: **(REQUIRED)**	NPI #:	Member Name:
Office Phone#: Office Fax#:	Contact Name:	Member ID #:
Vendor Name: **(REQUIRED)**	NPI #:	Member's Date of Birth:
Vendor Phone #: Vendor Fax #:	Contact Name:	Member's Phone #:
ICD-10 Code(s):		

Please answer questions below

HCPCS code(s) (REQUIRED): _____

1. What is the date of delivery/purchase? _ _/_ _/_ _ _ _
2. Why is the support device needed?
   _____
   _____
   _____
   _____
3. Is the LSO/TLSO being used to:
   a. Reduce pain by restricting mobility of the trunk? ☐ Yes ☐ No
   b. Facilitate healing following an injury to the spine of related soft tissues? ☐ Yes ☐ No
   c. Facilitate healing following a surgical procedure on the spine or related soft tissue? ☐ Yes ☐ No
   d. Support weak spinal muscles and/or a deformed spine? ☐ Yes ☐ No
   e. Is this a custom fabricated brace? ☐ Yes ☐ No
4. If this is a custom fabricated brace, please provide documentation regarding what was done to individually fit the member and why cutting, bending and molding was medically indicated.
   _____
   _____
   _____
   _____

I certify that I have appropriate authority to request an organization determination for the item(s) indicated on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time to verify this information.

Signature:_____ Date: _____

Please Return Completed Form to:
Fax: 1-336-794-1556
For questions, please call Care Management at 1-888-296-9790.