Security Health Plan℠
Promises kept, plain and simple.®

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

1.800.472.2363 | 715.221.9555
TTY: 711

Carpal Tunnel

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)		
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.

Is the EMG/NCS positive for median nerve compression at the wrist ☐ Yes ☐ No

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

- Night spells unrelieved by night time splinting ☐ Yes ☐ No
- Lingering subjective or objective numbness ☐ Yes ☐ No

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

Is there positive testing such as: Phalen's test, Tinel's sign, median nerve compression test ☐ Yes ☐ No

Is there sensory testing: Decreased light touch, 2-point discrimination or vibratory sense ☐ Yes ☐ No

Is there weakness of the arm muscles ☐ Yes ☐ No

Is 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
- Corticosteroid injection with documentation that ineffective or contraindicated (not tolerated or refused) ☐ Yes ☐ No
- Activity modification greater than or equal to 6 weeks ☐ Yes ☐ No

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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.

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