SecurityHealth 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: 1.877.727.2232 | 715.221.9898

Panniculectomy

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)

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.

Does the member's medical record contain documentation of recurrent rashes, dermatitis with skin ulceration and caused by the pannus that has not responded to conventional treatment for a period of 3 months? Conventional treatment includes adequate hygiene and oral or topical anti-infective medication ..... ☐ Yes ☐ No

If yes, submit medical record documentation supporting the above.

There is a presence of significant functional deficit that prohibits or profoundly impairs the ability to perform activities of daily living due to a significant physical deformity or disfigurement resulting from excess skin folds, and surgery is expected to restore or greatly improve the functional deficit ..... ☐ Yes ☐ No

Is the panniculectomy being performed as a secondary procedure to allow the primary surgical procedure to be performed and/or be successful (e.g. removal of the pannus for an incisional hernia repair) ..... ☐ Yes ☐ No

If yes, submit medical record documentation supporting the above.

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 1.800.472.2363.

