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: 711

Septoplasty

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 this for a septoplasty ☐ Yes ☐ No

Does the member have clinical findings of septal deviation or septal spurring ☐ Yes ☐ No

Has the member received maximum medical treatment for symptoms:

- Recurrent episodes of rhinosinusitis needing antibiotics (4 or more per year). A thorough allergy assessment to rule out allergic rhinosinusitis and elimination of rebound nasal congestion from overuse of nasal decongestant spray as a cause of rhinitis must be documented ☐ Yes ☐ No
- Recurrent epistaxis related to septal deformity after other causes ruled out ☐ Yes ☐ No
- Chronic rhinosinusitis for more than 12 weeks ☐ Yes ☐ No
- Nasal airway obstruction caused by septal deviation/deformity that has been poorly responsive to appropriate medical therapy for at least 6 weeks (e.g. intranasal steroids, nasal lavage, oral steroids, etc.). ☐ Yes ☐ No

Is this performed in association with cleft lip/cleft palate repair ☐ Yes ☐ No

Is this required for surgical repair of vestibular stenosis (surgery to repair collapsed internal valves leading to nasal obstruction). ☐ Yes ☐ No

Is this for an extracorporeal septoplasty ☐ Yes ☐ No

- Is the initial correction of an extremely deviated nasal septum that cannot adequately be corrected with an intranasal approach ☐ Yes ☐ No

Is there an asymptomatic septal deformity that prevents access to other intranasal areas when such access is required to perform surgical procedures (e.g. ethmoidectomy). ☐ Yes ☐ No

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.

