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

Total Hip Replacement

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 there pain in member's hip with activity (i.e. standing, walking, climbing stairs, getting in and out of vehicle) and weight-bearing that interferes with activities of daily living ..... ☐ Yes ☐ No

Are there physical findings demonstrating pain with passive range of motion, limited range of motion or antalgic gait ..... ☐ Yes ☐ No

Is there imaging (x-ray, MRI) demonstrating significant signs of degenerative change – such as subchondral cysts, subchondral sclerosis, periarticular osteophytes, joint subluxation, and joint space narrowing ..... ☐ Yes ☐ No

Does the member experience continued symptoms after conservative therapy with NSAIDs (duration greater than 4 weeks unless contraindicated or not tolerated), physical therapy (greater than 6 weeks with potential trial of external joint support) (i.e. bracing, cane, orthotics)..... ☐ 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

