HIGHMARK. Delaware

BONE DENSITY INFORMATION FORM

Directions: Please provide the information below in order to determine medical necessity for the bone density scan.

Please Note: *Men of any age and women younger than 45 years: An authorization is required for members with IPA/POS coverage. EPO/PPO/Traditional members: Claims are reviewed for medical necessity. Women 45 years and older: Authorizations and medical review are not required for any lines of business.*

PHYSICIAN INFORMATION:

Date: ___/___/___ **Physician's Name:** _____

Physician's Phone: (___) _____

Date of Service: ___/___/___

Name of Facility: _____

PATIENT INFORMATION:

Patient's Name: _____

Member ID#: _____ Patient's Age: _____

Is the patient menopausal? ❑ Yes ❑ No

Is patient on hormone replacement? ❑ Yes ❑ No If yes, date began: ___/___/___

Is the patient on medication to treat osteoporosis? ❑ Yes ❑ No If yes, date began: ___/___/___

Has the patient been on long term steroid therapy? ❑ Yes ❑ No

Is the patient being treated for any thyroid disease? ❑ Yes ❑ No

Has any osteopenia been demonstrated on X-ray? ❑ Yes ❑ No

Is there any history of fractures? ❑ Yes ❑ No

Date of last bone density scan: ___/___/___

Other pertinent information: _____

_____

Please fax the completed form to the Highmark Delaware Medical Management Department at 302.421.8864 or 800.670.4862.