Kansas Medical Assistance Program

Negative Pressure Wound Therapy Renewal Prior Authorization Request

FORM INSTRUCTIONS

1. This form must be completed by the MEDICAL STAFF who are currently caring for the beneficiary.
2. **The durable medical equipment (DME) provider MAY NOT fill out any part of this form.**
3. This form must be submitted to the Kansas Medical Assistance Program (KMAP) by the DME provider.
4. The DME provider must attach a completed General Prior Authorization Request Form prior to submitting to KMAP.
5. All spaces must be filled out completely. (Incomplete requests will be returned unprocessed.)
6. All information must be within 30 days prior to the dates being requested.
7. The DME provider must maintain supporting documentation in the beneficiary's file at all times.
8. Prior authorization (PA) requests will be considered for up to 30 days at a time. (Backdating is not allowed.)
9. The request must include a copy of the physician's prescription for continued use, current labs, and physician office note from prior 30 days.

PLEASE PRINT ALL INFORMATION LEGIBLY.

BENEFICIARY NAME	BENEFICIARY ID NUMBER	
NAME OF HOME HEALTH AGENCY	PHONE NUMBER	FAX NUMBER
PHYSICIAN NAME	PHONE NUMBER	FAX NUMBER
SERVICE DATES	ESTIMATED LENGTH OF NEED	

BENEFICIARY COMPLIANCE OF WOUND HEALING PROMOTION (PLEASE DESCRIBE):

LIFESTYLE CHANGES MADE TO PROMOTE HEALING AND PREVENT REOCCURENCE:

BENEFICIARY IS CURRENTLY IN (CHECK ONLY ONE):

- ☐ SKILLED NURSING FACILITY
- ☐ HOSPITAL
- ☐ SPECIALTY HOSPITAL
- ☐ HOME
- ☐ GROUP HOME
- ☐ ASSISTED LIVING
- ☐ OTHER FACILITY:

UPCOMING DISCHARGE DATE (IF APPLICABLE):

LABS

PLEASE INCLUDE DATE DRAWN FOR EACH LAB.

ALBUMIN	PREALBUMIN	HgbA1C (IF REDRAWN)	HEMATOCRIT
HEMOGLOBIN			

WOUND EVALUATION WEEK ONE				
	WOUND A	WOUND B	WOUND C	WOUND D
LOCATION				
SIZE (W X L X D)				
FREE OF NECROTIC TISSUE/ESCHAR (yes/no)				
STAGE/GRADE				
DRAINAGE-color, odor, amount				
TUNNELING-amount, location				
UNDERMINING-amount, location				
WOUND EVALUATION WEEK TWO				
	WOUND A	WOUND B	WOUND C	WOUND D
LOCATION				
SIZE (W X L X D)				
FREE OF NECROTIC TISSUE/ESCHAR (yes/no)				
STAGE/GRADE				
DRAINAGE-color, odor, amount				
TUNNELING-amount, location				
UNDERMINING-amount, location				
WOUND EVALUATION WEEK THREE				
	WOUND A	WOUND B	WOUND C	WOUND D
LOCATION				
SIZE (W X L X D)				
FREE OF NECROTIC TISSUE/ESCHAR (yes/no)				
STAGE/GRADE				
DRAINAGE-color, odor, amount				

TUNNELING-amount, location				
UNDERMINING-amount, location				

WOUND EVALUATION WEEK FOUR

	WOUND A	WOUND B	WOUND C	WOUND D
LOCATION				
SIZE (W X L X D)				
FREE OF NECROTIC TISSUE/ESCHAR (yes/no)				
STAGE/GRADE				
DRAINAGE-color, odor, amount				
TUNNELING-amount, location				
UNDERMINING-amount, location				

List any changes in NPWT or medical care within the last month:

Was debridement performed within the last 30 days? If so, list dates and to which wound (A,B,C,D):

ADDITIONAL COMMENTS

ALL INFORMATION ON THIS FORM IS TRUTHFUL AND CORRECT. I AM NOT EMPLOYED BY THE DME PROVIDER. I HAVE PERSONALLY SEEN AND CURRENTLY PROVIDE MEDICAL CARE FOR THIS BENEFICIARY IN HIS OR HER HOME OR ON AN OUTPATIENT BASIS.

MEDICAL STAFF NAME
(PLEASE PRINT LEGIBLY.)

MEDICAL STAFF SIGNATURE	TELEPHONE NUMBER
TITLE	DATE