Clear Form

Minnesota Department of **Human Services**

DHS-4437-ENG 8-11

Minnesota Health Care Programs (MHCP)

Prosthetics and Orthotics Authorization Form

ASSIGNED NUMBER FROM MN–ITS

Use this form in addition to the MN–ITS Authorization Request transaction or the Authorization Form (DHS-4695) to request authorization for prosthetics and orthotics. Fax this form with any additional or required documentation to the medical review agent.

If you need more space, continue answers on separate sheet and indicate question you are answering.

Provider Information

PROVIDER NAME	NPI/UMPI
CONTACT NAME	PHONE NUMBER ( )

Recipient Information

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	MHCP ID NUMBER

PRIMARY DIAGNOSIS CODE	DESCRIPTION	HEIGHT
SECONDARY DIAGNOSIS CODE	DESCRIPTION	WEIGHT

MEDICARE FUNCTIONAL LEVEL ASSESSMENT

CAUSE OF AMPUTATION OR REASON FOR NEED OF ORTHOSIS

RELATED PHYSICAL CHARACTERISTICS

SPECIAL OCCUPATIONAL NEEDS

ASSESSMENT OF FUNCTIONAL LEVEL

Recipient currently has a prosthetic/orthotic ☐ Yes ☐ No	AGE OF PROSTHETIC/ORTHOTIC

DESCRIBE CURRENT PROSTHETIC/ORTHOTIC, ACCURACY OF FIT, MECHANICAL OR STRUCTURAL CONDITION, AND APPROPRIATENESS

INDICATE HOW OFTEN CURRENT PROSTHETIC/ORTHOTIC DEVICE IS BEING USED

AFTER INSPECTION OF CURRENT DEVICE, INDICATE IF ANY OF THE ITEMS COULD BE REUSED, REPAIRED OR REPLACED. IF NO, EXPLAIN.

INDICATE IF CONDITION HAS CHANGED SIGNIFICANTLY (E.G. WEIGHT GAIN/LOSS, OCCUPATIONAL CHANGE, NEW DIAGNOSIS, CHANGE IN MEDICATIONS)

REASON FOR REPLACEMENT OF THIS ITEM

☐ Medical ☐ Functional

EXPLAIN:

LIST LESS COSTLY ITEMS WITHIN RECIPIENT NEEDS TRIED, AND OUTCOME

OTHER IMPORTANT INFORMATION

SIGNATURE OF ORTHOTIST/PROSTHETIST	DATE
SIGNATURE OF PT/OT/OTHER PROFESSIONAL INVOLVED IN EVALUATION AND CREDENTIALS	DATE
NAME OF PHYSICIAN – ATTACH PRESCRIPTION FROM PHYSICIAN	DATE