

Capsule Endoscopy Authorization form

This is confidential information intended only for the person to whom it is faxed.

HCA requires all fields to be completed so we can appropriately evaluate the request. Please return this form by **online** direct data entry (hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/prior-authorization-pa) or by **fax** along with the *General Information for Authorization (GIA) form (13-835)* to Authorization Services at **1-866-668-1214**. The GIA form must be typed and must be page one of your fax (no fax coversheet).

1

Provider information

Provider name

Provider NPI

Phone number

Fax number

2

Client information

Client name

ProviderOne client ID

3

Service request information

Description of service being requested

Procedure code

Number of units requested

Number of units used this year

4

Medical information

Dates of injury or illness

Diagnosis code

Diagnosis description

Diagnosis code

Diagnosis description

Place of service

Date of planned capsule endoscopy

Previous capsule endoscopy:

Yes

No

If yes, date of previous endoscopy:

Date of last colonoscopy:

Findings:	Normal	Abnormal
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If abnormal, explain:

Date of last esophagogastroduodenoscopy (EGD):

Findings:	Normal	Abnormal
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If abnormal, explain:

Does the client have a history of gastrointestinal obstruction?	Yes	No
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Does the client have a dx of (mark all that apply):

Obscure or occult gastrointestinal (GI) bleeding

Suspected Crohn's disease

Known Crohn's disease

Suspected small bowel lesion

Celiac disease

Peutz-Jeghers syndrome (PJS) by genetic testing or clinical findings or family history

Other:

Include H/P, results of colonoscopy, EGD, MRI/CT (if applicable).