Print Form

BlueCross BlueShield of Illinois

Hyperbaric Oxygen (HBO) Pressurization

Hyperbaric Oxygen (HBO) Pressurization
Medical Policy – THE801.003

Please complete all appropriate questions fully.

Suggested medical record documentation:

- Current History & Physical
- Consultation Reports
- Operative or Treatment Reports (other applicable hospital records)
- Provider Office Reports
- Photographs

*Failure to include suggested medical record documentation may result in delay or possible denial of request.

Note: Per Medical Policy, HBO therapy using topical HBO pressurization for any indication or clinical condition is considered experimental, investigational and unproven.

PATIENT INFORMATION

Name:	Member ID	Group ID

PROCEDURE INFORMATION

Request for Systemic HBO: Please complete all the questions fully.
Failure to do so will result in delay or possible denial of claims.

Primary Diagnosis _____ Date _____

Secondary Diagnosis _____ Date _____

Contributing Factor(s) resulting in diagnosis _____
_____
_____
_____
_____

Conservative Therapy done? Yes _____ No _____

If Yes, type and duration of Conservative Therapy _____
_____
_____
_____
_____ # of Months _____

For Wounds, Photographic Evidence included with HBO request? Yes _____ No _____

Is this an initial request for HBO? Yes _____ No _____

If Yes, number of treatments (or dives) requested _____

If No, number of previous treatments (or dives) completed _____

If No, number of additional treatments (or dives) requested _____

Part A – IF Condition is a Wound

Cause of wound _____
_____
_____

Location of wound _____

Description of wound _____
_____
_____

Wound measurements _____
_____

Pathology or Culture report of wound _____

Wagner Classification of Wound (Grade #) _____

Proceed to Part B if Request is for additional HBO Treatments (or Dives) ONLY

Part B – Additional HBO Treatment Requests

Explanation of Reason for additional Systemic HBO Therapy: _____
_____
_____
_____

Is additional Conservative therapy being planned? Yes _____ No _____

If Yes, type and duration of Conservative Therapy _____
_____
_____ # of Months _____

In addition, IF the request is due to a wound, complete the following:

Current Description of wound _____
_____
_____

Current Wound measurements _____
_____
_____

Previous Weekly Wound measurements for comparison and progression of healing since last request:

Date	Wound Size (cm)	Wound depth (cm)	Undermining (cm)	Granulation
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current Wagner Classification of Wound (Grade #) _____

For Wounds, updated Photographic Evidence included with HBO request? Yes _____ No _____