Prior Authorization Request **Percutaneous Tibial Nerve Stimulation (PTNS)**

Provider

Physician Name_____

Contact Name_____ NPI _____

Practice Name _____ Phone_____

Fax_____ E-mail_____

Patient

Patient Name _____ Patient DOB_____/_____/_____

Insurance_____ Member name _____

Member ID #_____ Group #_____

Procedure
CPT® Code 64566

Percutaneous Posterior Tibial Nerve Stimulation – 12 treatments

CPT® Code 64566- *Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming.*

ICD-9 Diagnosis: ☐788.31 urge incontinence ☐788.41 frequency ☐788.63 urgency ☐Other _____

ICD-10 Diagnosis: ☐N39-41 urge incontinence ☐R35.0 frequency ☐R39.15 urgency ☐Other _____

Approx. Date of Service for 1st Treatment_____ (Therapy is 12 weekly treatments)

Medical Necessity

Duration of Symptoms _____☐months ☐years

Symptoms: ☐Frequency ☐Urgency ☐Urge-Incontinence ☐Night-time frequency ☐Other _____

Severity (1=minimal impact to patient's life, 5=severe disruption to patient's life): ① ② ③ ④ ⑤

Conservative Therapies Tried	Pharmacological Therapies Tried	Reason(s) Discontinued
☐ Fluid Management	Drug _____	☐ Insufficient Response
☐ Nutrition Counseling	Duration_____	☐ Patient compliance
☐ Timed Voids	Drug_____	☐ Side Effects
☐ Pelvic Floor Exercises	Duration_____	☐ Other _____
☐ Biofeedback		_____
☐ Other_____		

I am requesting coverage for the above patient for 12 treatments of PTNS delivered via the Urgent® PC Neuromodulation System.

_____ _____ _____

Office Signature Date Fax

Authorization #_____

Authorized by_____ Date_____