ARC
Aquablation Reimbursement Center

PROCEPT BioRobotics Corporation

PRIOR AUTHORIZATION INTAKE FORM:
E-mail:* reimbursement@Aquablation.us *or FAX: 650-649-1856
Hours: Monday-Friday 10AM – 5PM CT

For accurate and timely processing, submit the following **with this signed** prior authorization form:

- **Patient Demographic Information Sheet**
- **Patient insurance cards (copies of both front and back)**
- **Patient history (relevant to the clinical indication)**
- **Patient progress notes (relevant to previous tests, medical management, etc.)**

Allow ample time prior to the service date to accommodate payer responses and follow-up

Patient and Insurance Information

Primary Insurer: Click to enter text	Patient ID/Policy Number: Click to enter text
Name of Insured: Click to enter text	Patient Date of Birth: Click to enter text
Secondary Insurer: Click to enter text	Patient ID/Policy Number: Click to enter text
Name of Insured: Click to enter text	

Servicing Physician Information

Practice Name: Click to enter text	
Physician: Click to enter text	TIN/NPI: Click to enter text
Practice Tax ID Number: Click to enter text	Physician PTAN: Click to enter text
Physician State License: Click to enter text	Effective Date: Click to enter text Expiration Date: Click to enter text
Physical Address: Click to enter text	Physician UPIN: Click to enter text
Primary Office Contact: Click to enter text Email: Click to enter text	Phone: Click to enter text Fax: Click to enter text
Procedure Date of Service: Click to enter text	In network ☐ Out of network ☐
Site of Surgery: ☐ Inpatient ☐ Hospital Outpatient	

Servicing Hospital Information

Facility Name: Click to enter text	TIN/NPI: Click to enter text
Physical Address: Click to enter text	Phone: Click to enter text
Tax ID Number: Click to enter text	Facility PTAN: Click to enter text
Facility Contact: Click to enter text	In network ☐ Out of network ☐
Email: Click to enter text	Phone: Click to enter text

For Office and ARC use only

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Clinical Information (Medical Record Documentation)

ICD-10-CM Diagnoses (please provide complete code; see code prefixes in table below for reference.

Primary Diagnosis: Click or tap here to enter text.

Secondary Diagnosis: Click or tap here to enter text.

Possible ICD-10-CM Diagnosis Codes Prefixes*			
N31.-	Neuromuscular dysfunction of bladder, not elsewhere classified	N40.-	Benign prostatic hyperplasia
N32.-	Other disorders of the bladder	R30.-	Pain associated with micturition
N33.-	Bladder disorders in diseases classified elsewhere	R31.-	Hematuria
N35.-	Urethral stricture	R32.-	Unspecified urinary incontinence
N36.-	Other disorders of the urethra	R33.-	Retention of urine
N37.-	Urethral disorders in disease classified elsewhere	R34.-	Anuria and oliguria

* Please refer to the 2019 ICD-10-CM Codebook to select the complete codes and other diagnosis codes that may apply

CPT Code (Please refer to current year CPT manual for complete code descriptions)

CPT Code		**Description**
☐	0421T	Transurethral waterjet ablation of prostate, including control of post-operative bleeding, including ultrasound guidance, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included when performed)
List other CPT Codes as applicable		**Description**
☐	Click or tap here to enter text.	Click or tap here to enter text.

Procedure coding for the hospital if the patient will be admitted as an inpatient

ICD-10-PCS Code		**Description**
☐	XV508A4	Destruction of prostate using robotic waterjet ablation, via natural or artificial opening endoscopic, new technology group 4

Clinical Signs and Symptoms: (reason for procedure including previous treatments)

Click or tap here to enter text.

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Physician Verification

By submitting this form to the Aquablation Reimbursement Center, the physician identified has either completed this document in its entirety or reviewed upon completion by employee. The information, including the patient diagnosis, codes selected, and medical documentation is true, accurate, and complete. The physician also verifies that this procedure is medically necessary.

Providers must submit accurate and appropriate claims for services. It is always the provider's responsibility to determine medical necessity, the proper site for delivery of any services and to submit appropriate codes, charges and modifiers for services that are rendered.

Please fax or email patient clinical documentation (e.g., treatment history) and insurance information along with the pre-authorization form.

Physician Signature Click or tap here to enter text.

Date Click or tap to enter a date.

Primary Contact Name: Click or tap here to enter text.

Primary Contact Phone: Click or tap here to enter text.

Primary Contact email: Click or tap here to enter text.

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