WTC-5 Medical Code Request Form

(ex: ICD, CPT, HCPCS, DME)

Submission Instructions: Please complete this form and send it to the World Trade Center Health Program at WTCMedCode@csc.com. Please do not include any member personally identifiable information (PII). Incomplete forms will be sent back for more information.

| Requester Information | | | | | | |
|--|-------------------|-----------------------------|--|--|--|--|
| Request Date | | Choose a CCE/NPN | | | | |
| Requester Name | | | | | | |
| Requester E-mail | | Requester Phone | | | | |
| Clinical Director Name | | Clinical Director Signature | | | | |
| Request Urgency | Urgency Rationale | | | | | |
| ○ Urgent○ Routine | | | | | | |
| Code Request Information | | | | | | |
| Code Type | Code Number | Code Description | | | | |

| include medical/scientific evidence-based info to a WTC-related/medically associated condit condition, please note to which WTC-related (progression of the WTC-related condition, du | dition or procedure/service represented by this code. Please also formation on the medical necessity of this code and its relationship lition. If request is for an ICD code addition as a WTC–Associated condition it is being associated and how it is associated ue to treatment of the WTC-related condition, etc.). Please identify rovide to the WTCHP in relation to similar codes that are already |
|--|--|
| Reques | sted Codebook Placement |
| Condition Type | |
| Placement for ICD Code Request | Adjustment Disorder Anxiety Cancer Diagnostics Cancer Treatment Depression Diagnostics Gastroesophageal Reflux Disease Interstitial Lung Disease (including Sarcoid) Monitoring Musculoskeletal Disorders Obstructive Airway Disease Post Traumatic Stress Disorder Substance Abuse Survivor Screening |
| | ☐ Upper Respiratory Disease☐ Other |

| Placement for Procedure Code Request | ☐ Cancer Dia☐ Cancer Tre☐ Diagnostics☐ Monitoring☐ Survivor Sc | atment | |
|---|--|--------------------|----------------------|
| CCE/NPN Clinical Direct | ☐ Treatment or Comments | and Approval of Re | quest |
| CCE/NPN Clinical Director Comments: | | | |
| | | | |
| | | | |
| | | | |
| CCE/NPN Clinical Director Signature and | Credentials | Date Signed: | |