Request for Benefit Consideration

Medical Product or Service

SANFORD HEALTH PLAN

CONTENTS

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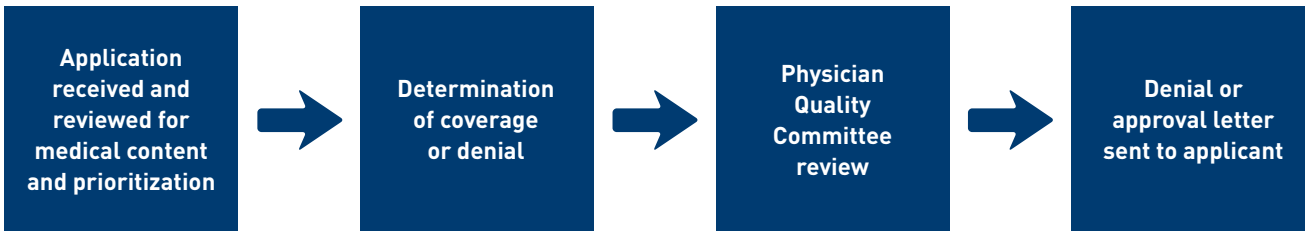
GENERAL INSTRUCTIONS AND OVERVIEW

As a collaborating partner in the health care industry, Sanford Health Plan recognizes the value of our relationships with our providers and their knowledge of new and upcoming medical innovations. We understand and acknowledge the mission of health care delivery, safety and quality to our respective members. As part of Sanford Health's large organization, we follow their mission statement of:

Dedicated to the work of health and healing

This package provides you with a vehicle in which to communicate your request for benefit coverage consideration for a specific new medical service or product. Completing this request does not guarantee coverage of benefits, and the request must be completed prior to claim submission of the new product or service.

The image below illustrates the process to review your request for benefit consideration. Our process will consider factors such as medical impact, safety, efficacy, clinical trial phase and cost-to-benefit ratios. Our goal is to deliver a timely determination to you, especially for a specific member; however, this process may take several months to be incorporated into a covered benefit option.



[Medical review & evaluation]

[Actuarial, claims testing, legal, I.T. review]

Where to submit

When you have completed this request for consideration, email this document, along with all supporting documentation to um@sanfordhealth.org

If you have questions while completing this document, contact one of our medical directors at (605) 328-6807.

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COMPLETE THE REQUEST FOR CONSIDERATION

Contact information

Requestor name (individual completing form)	Requestor training/certification	
Requestor organization (facility/clinic name or employer)		
Organization address		
City	State	Zip code
Phone	Email address	

Primary contact person, if different than above	
Phone	Email address

Sponsoring organization and/or manufacturer (if applicable)		
Address		
City	State	Zip code

☐ Product/Device ☐ Service

Description of service, device, or product

Associated codes – *Required for submission*

ICD-10	CPT	Modifiers
HCPCS	Other planned billable codes	

Financial conflict declaration

A financial conflict does not automatically exclude your request for consideration. However, you do have a duty to disclose the conflict. In connection with any actual or possible conflict of interest, an interested person must disclose the existence of the financial interest and be given the opportunity to disclose all material facts to the directors and members of committees who are considering the proposed request for consideration.

☐ No conflict ☐ Yes, please explain

Are you currently working on a project with any research institution/facility, device manufacturer or pharmaceutical company?

☐ No ☐ Yes, please explain

I understand that the information contained in this request for consideration is not a guarantee for current and/or future benefit coverage nor a guarantee for reimbursement.

Requestor signature **Date**

_____ ____/____/____

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ABSTRACT DESCRIPTION OR REQUEST

State the objectives of the proposal with reference to its potential impact on health care. Specific practice or patient experience is accepted.

If you are requesting coverage for a particular **medical service,** include responses to the following questions:

- ✓ Does the service require a unique training?
- ✓ Does the requester have financial interests or a relationship with a company that is involved with this type of service? If so, explain.
- ✓ Are you a Sanford Health Plan contracted provider?
- ✓ Does the medical service replace an existing service already covered? If so, what are the advantages?
- ✓ What criteria are you using to determine appropriateness for your patient(s)? (Attach criteria)
- ✓ Is this service in clinical trials? What is the trial name and assigned number? (Attach trial documentation and web link to the trial)
- ✓ Is the service already provided by others in your community or system? If so, by whom and/or what system?
- ✓ Will this service need to be repeated?
- ✓ What are the alternatives to the service if it is not a covered service?
- ✓ Based on the proposed cost for the service, how do you see it being integral to treating your patient?
- ✓ Do you have previous experience on the value of this service to a patient? Please describe.

Answer the questions in the space below if you are requesting coverage for a **medical service.**

If you are requesting coverage for a particular **medical product,** include responses to the following questions:

- ✓ Is the product sold in Sanford affiliated facilities?
- ✓ Is the product FDA approved?
- ✓ Is this product in clinical trials? What is the trial name and assigned number? (Attach trial documentation and web link to the trial)
- ✓ Is the product covered under the CMS DME benefit?
- ✓ Is the vendor product superior to similar products in the field?
- ✓ What criteria are you using to determine appropriateness for your patient(s)? (Attach criteria)
- ✓ What is the expected time the product will last in normal situations?
- ✓ Are you a Sanford Health Plan contracted provider?
- ✓ Do you have any financial conflicts to declare in the promotion or prescribing of this product?

Answer the questions in the space below if you are requesting coverage for a **medical product.**

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ABSTRACT DESCRIPTION OR REQUEST

This portion of the application represents the body of scientific data that supports the proposed request for review process. This data should be obtained from peer review and scholarly sources. You may include up to, but not exceeding, 10 (ten) articles. Simply list the open access online links to the articles. If a subscription access is needed to access the article online, the full article must be attached to the request. These articles will be used in the review process and determination.