Prostatic Urethral Lift Coverage Summary Checklist

Patient Name: Date:

MRN: Physician:

Health Plan Name:

Covered Codes

Prior Authorization Requirements

Coverage Criteria	Enter Patient Result for Each Criteria	Page #

All medical necessity criteria should be documented in the medical record. Reference complete medical policies available on the health plan website or at https://urolift.policyacumen.health/.

**A health plan's medical necessity criteria may not match the current FDA indication for the UroLift® System. See more information on FDA indications at www.urolift.com.*

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