



33049



Spinal Surgery Prior Authorization Request Form

- Instructions:**
1. Use this form when requesting prior authorization of Spinal Surgery procedures for members of EmblemHealth.
 2. Please complete and Fax this request form along with all supporting clinical documentation to OrthoNet at 1-844-296-4440.
(This completed form should be page 1 of the Fax.)
 3. For assistance in completing this form, or if you should have any question about whether or not the procedure requires prior authorization, please contact OrthoNet toll free at 1-844-730-8503 for Spinal Surgery procedures.
 4. Please PRINT, in black ink, one character per box for ALL requested information and completely fill in each circle for selection where applicable.

NOTE: The information transmitted is intended only for the person or entity to which it is addressed and may contain CONFIDENTIAL material. If you receive this material / information in error, please contact the sender and delete or destroy the material/information.

PROVIDER INFORMATION:

Fax Date: / /

Number of pages faxed : (including this cover page)

Facility or Provider Name

Street Address

City

State

ZIP

Telephone Number

() -

National Provider Identifier (NPI)

Facility NPI Number

Individual NPI Number

Fax Number

() -

Provider Tax ID Number

Facility Tax ID Number

Individual Tax ID Number

PATIENT INFORMATION:

First Name

Last Name

Date of Birth

/ /
Month Day Year

Diagnosis Code (ICD-10 Format)

Health Plan Member ID Number

REQUEST INFORMATION:

Request for:

- Spinal Decompression
- Spinal Fusion
- Vertebroplasty/Kyphoplasty
- Other

Spinal Region(s):

- Cervical
- Thoracic
- Lumbar

Spinal Level(s):

Setting:

- Inpatient
- Outpatient
- Observation

Has the patient had prior spinal surgery? Yes No N/A

Anticipated Date of Service(s)

/ /
Month Day Year

Has the patient had an MR/CT in the past 6 months? Yes No N/A

Is the MR/CT report attached to this request? Yes No N/A

If yes, what was the most recent date of surgery? / /
Month Day Year

CPT Code(s):

Please attach to this fax submission the current office notes (3 months) that support the proposed procedure.

Requested Facility for Surgery/Procedure(s) (If Applicable)

City

State

Facility Tax ID Number



Copyright 2015 OrthoNet LLC

For Internal Office Use Only
OA OS OP

Shade Circles Like This Not Like This

33049

