33049

EmblemHealth

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.

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

Anticipated Date of Service(s) ☐☐ / ☐☐ / ☐☐☐☐ (Month / Day / Year)

	Yes	No	N/A
Has the patient had prior spinal surgery?	○	○	○
Has the patient had an MR/CT in the past 6 months?	○	○	○
Is the MR/CT report attached to this request?	○	○	○

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**

Reset

For Internal Office Use Only ○ A ○ S ○ P

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OrthoNet