Orthopedic Spine Procedure Prior Authorization Form

HealthSpring℠

To allow more efficient and accurate processing of your request, fax this completed form and all supporting clinical documentation to 866-287-5834.

Member name	HealthSpring member ID	Member date of birth	Date of planned surgery

Diagnosis	ICD-10 diagnostic codes

Procedure

Procedure

Current Procedural Terminology (CPT®) codes
Provide all CPT codes; additional code lists may continue on next page.

CPT codes not listed above

Hardware used

Specify the spinal level	Surgeon name

I confirm the member has not smoked or otherwise used tobacco products within the past six weeks. ☐ Yes ☐ No

Tobacco use history Non-smoker ☐ Yes ☐ No Former smoker – quit date _____

Former smokeless tobacco user – quit date _____

Vaping ☐ Yes ☐ No

The following clinical information must be included in your request to permit a timely review by HealthSpring.

Chief complaint, onset of symptoms and primary location

Symptoms of myelopathy/radiculopathy

☐ Weakness ☐ Gait imbalance ☐ Paresthesias ☐ Loss of sensation ☐ Bowel or bladder dysfunction ☐ Myelopathy

☐ Radiculopathy ☐ Difficulty with fine motor movements ☐ Pain (identify location) _____

☐ Other (please specify) _____

Functional limitations

☐ Inability to perform household chores ☐ Mild ☐ Moderate ☐ Severe

☐ Difficulty with walking or standing for extended time ☐ Yes ☐ No

☐ Inability to complete essential job functions ☐ Mild ☐ Moderate ☐ Severe

☐ Falls ☐ Rare 1-2 times a month ☐ Weekly ☐ Daily

☐ Difficulty with fine motor movements ☐ Yes ☐ No

Conservative treatment

☐ Exercise ☐ Nonsteroidal and/or steroidal medications or contraindications ☐ Physical therapy

☐ Steroid injections location _____ Date _____

Degree of relief _____

Objective physical examination/findings: This could include sensory changes, motor weakness, reflex changes, sustained clonus, Babinski test, toe-to-heel walk, Romberg test, loss of sacral sensation or sphincter tone.

Reports of all diagnostic studies performed

1. X-ray findings Date _____

2. MRI or CT scan findings Date _____

3. CT myelography Date _____

If prior fusion surgery:

When was the prior surgery?

What level(s) were previously fused or decompressed?

Date the member last saw the provider