40728

Humana Musculoskeletal Surgical Prior Authorization Request Form

Instructions: 1. Use this form when requesting prior authorization of Musculoskeletal Surgery procedures for Humana Commercial and Medicare Advantage members.
2. **Please complete and Fax this request form along with all supporting clinical documentation to OrthoNet at 1-866-621-9008.**
3. Please ensure that this form is a DIRECT COPY from the MASTER.
4. Please PRINT, in black ink, one character per box for ALL requested information and completely fill in each circle for selection where applicable.
5. For assistance in completing this form, please call OrthoNet provider services toll free at 1-866-565-4733.

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.

PATIENT INFORMATION

Fax Date:_____ # of Pages Faxed:____

First Name | Last Name | Date of Birth (Month / Day / Year)

Humana Member ID Number | Suffix | Diagnosis Code (ICD-10 Format)

MUSCULOSKELETAL SURGICAL PROVIDER INFORMATION

Provider Name

Street Address

City | State | ZIP

Telephone Number ( ) -

Provider Tax ID

Fax Number* ( ) -

** The above fax number will be used to confirm your address/ location if we are unable to contact you using the fax number on file with the Health Plan.*

REQUEST INFORMATION

Setting:
- ○ Inpatient
- ○ Outpatient
- ○ Observation

Site:
- ○ Right
- ○ Left
- ○ Bilateral

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

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

Please include the current office notes (3 months) that support the proposed procedure including any radiology.

CPT Code(s):

Requested Facility for Surgery/ Procedure(s)

Street Address

City | State | Facility Tax ID

OrthoNet

For Internal Office Use Only ○A ○S ○P

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