53922

HUMANA Spinal Surgery
Prior Authorization Request Form

Instructions: 1. Use this form when requesting prior authorization of Spinal Surgery procedures for Humana members.
2. **Please complete and Fax this request form along with all supporting clinical documentation to OrthoNet at 1-888-605-5345.** (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 1-866-565-4733 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) ☐☐

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)

HUMANA Member ID Number ☐☐☐☐☐☐☐☐☐☐

Diagnosis Code (ICD-10 Format) ☐☐☐.☐☐☐☐

REQUEST INFORMATION:

Request for:
○ Spinal Decompression
○ Spinal Fusion
○ Vertebroplasty/Kyphoplasty

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**

For Internal Office Use Only ○A ○S ○P

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OrthoNet

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