



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  
 Has the patient had prior spinal surgery?  Yes  No  N/A  
 If yes, what was the most recent date of surgery?  /  /   
 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

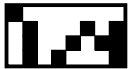
**CPT Code(s):**     
 Please attach to this fax submission the current office notes (3 months) that support the proposed procedure.

**Requested Facility for Surgery/ Procedure(s) (If Applicable)**  
  
**City**  **State**  **Facility Tax ID Number**

For Internal Office Use Only  
 OA OS OP

Shade Circles Like This  Not Like This

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