Health Tradition
P.O. Box 188
La Crosse, WI 54602-0188
Telephone: 608-781-2118
Toll-Free: 1-888-758-7848
Fax: 608-781-9654

Prior Authorization Request for Balloon Kyphoplasty Procedure (2 Page Form)

Health Tradition Health Plan requires prior authorization for balloon kyphoplasty. **The patient must be under care for a painful compression fracture by either a Physical Medicine & Rehab Provider or an Oncologist, if an osteolytic metastasis is present.**

All the requested information MUST be provided on the form below. Medical record notes or Letter of Necessity will not be accepted.

Receiving incomplete information will delay the processing of the request or may result in a denial.

First Name:_____ M.I. _____ Last Name:_____

DOB:_____ Medical Record Number: _____

Address:_____
street city state zip

Insurance Plan:_____ Insurance Number:_____

Patient is being referred to:_____ Date:
(Include name of practitioner providing kyphoplasty, the facility name and anticipated date of procedure)

Diagnosis:

If diagnosis includes osteolytic metastasis, has painful compression fracture occurred due to the metastasis?
(If yes, Oncologist must submit the prior authorization) Yes_____ No_____

……

Do you certify the presence of the following?

Thoracic kyphosis >15% OR lumbar segmental kyphosis > 10% documented on radiography?	**YES**	**NO**
Height reduction of fractured vertebral body at least 1/3 compared to adjacent vertebrae?		
Pain resulting from the fracture has not significantly improved after a reasonable attempt of conservative therapy?		

Radiology Signature to Certify:

……

Does the patient currently have any of the following?

	YES	NO
Uncorrected anticoagulation disorder		
Presence of infection (local or systemic)		
Known allergy to any of the materials used in the procedure		
Acute burst or a high-energy fracture		
Unstable vertebral fracture(s)		
Retropulsed tissue present		
Pregnant		

Describe and document range of dates of conservative treatment:

Pain resulting from the fracture has not significantly improved after a reasonable attempt of conservative therapy?

Physical Medicine Rehabilitation signature _____

Dept. Phone for questions:_____

Name of person completing form if different from Practitioner:_____