

Prior Authorization Form



NOTE: Refer to the Provider Manual for additional services requiring Prior Authorization

Fax Form To: Grand Rapids – 616 942-0024 Holland – 616 392-7626 ASO – 616 395-4090 Traverse City – 231 932-9505 Farmington Hills – 888 647-6152

*Spine Referral for Neurosurgeon or Orthopedic Surgeon Evaluation

*Only required for members 18 years of age and above.

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____

Plan/Product Type: HMO ASO (self-funded) POS Medicaid MICHild Medicare

Primary Care Physician: _____ PCP Phone: _____ PCP Fax: _____

Has PCP been notified of request? Yes No Is this authorization related to: Work Injury Motor Vehicle Accident

Requested By:

Provider Name: _____ Phone: _____ Fax: _____

Address: _____ Contact Name: _____

_____ Date of Request: _____

Directed To:

Provider Name: _____ Facility: _____

Address: _____ Address: _____

Provider Phone: _____ Fax: _____ Facility Phone: _____ Fax: _____

Clinical Information:

Diagnosis, if known: _____ Diagnosis Code _____

- (1) Evidence of tumor, infection or fracture.
- (2) Acute weakness of both arms, or of both legs (paraparesis or unsteady gait) especially if associated with any of the following:
 - upper motor neuron signs (Babinski or Hoffman's signs, clonus, hyperreflexia) and/or
 - loss of bladder or bowel control and/or
 - cord compression with decreased T1 signal changes, increased T2 signal changes, or signal changes at multiple cord levels on MRI.
- (3) Cauda equina syndrome (new onset of bowel or bladder dysfunction with areflexia, asymmetric paraparesis)
- (4) Follow up to emergency care in the emergency department or inpatient setting. Date(s) _____
Please attach notes.
- (5) Patient does not meet criteria in 1-4 but has been evaluated by a Back Pain Center of Excellence.
*Name of Center of Excellence/Provider Seen _____ Date _____
*Please attach with this authorization request the Center of Excellence notes/evaluation.
- (6) Patient has not been to a Center of Excellence and does not meet any of the conditions listed in criteria 1-5 above.
Please provide reason for referral to neurosurgeon/orthopedic surgeon. _____

ALL FIELDS MUST BE COMPLETE AND LEGIBLE FOR PRIOR AUTHORIZATION REVIEW

FOR OFFICE USE ONLY

- Authorize consult only
- Redirect to a Spine Center of Excellence
- Other _____

Office notified via fax _____
Member notified of approval denial via phone
By: _____ Date: _____