

Today's Date & Time:
Provider Contact Name:
Provider Contact Phone:
Provider Contact Fax:
Provider Name:
Provider TIN:
Provider NPI:
Practice/Group Name:
Provider Physical Address:
Provider Mailing Address (if different):

Member Name:
Date of Birth:
Member ID (including any alpha prefix):
Health Plan:
Notification Method Preference: <input type="checkbox"/> Postal Mail <input type="checkbox"/> Fax *Please be sure mailing address or fax number is provided.
Notes:

Requested Procedure:	Anticipated Surgery Date:
CPT/HCPCS or ICD Procedure Code(s):	
Diagnosis Code(s):	
Facility Setting: <input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Outpatient / Observation <input type="checkbox"/> Ambulatory Surgical Center	
Facility Name:	Facility Contact Name:
Facility TIN:	Facility Contact Phone:
Facility NPI:	Facility Contact Fax:
Facility Physical Address:	Facility Mailing Address (if different):
Patient's Height: _____	Patient's Weight: _____
Patient's BMI: _____	

<p>Does the patient have any of the following co-morbidities? Select all that apply.</p> <ul style="list-style-type: none"> <input type="radio"/> Diabetes that requires medication or insulin (Type I or Type II) A1C Level: _____ <input type="radio"/> Hypertension requiring medication <input type="radio"/> Previous cardiac event <input type="radio"/> Congestive heart failure <input type="radio"/> Dyspnea <input type="radio"/> Current smoker within past 12 months <input type="radio"/> History of severe COPD <input type="radio"/> Dialysis <input type="radio"/> Acute renal failure <input type="radio"/> Ascites within past 30 days <input type="radio"/> Steroid use for chronic condition <input type="radio"/> Disseminated cancer <input type="radio"/> None of the above 	<p>Patient's Activities of Daily Living (ADL) Functional status:</p> <ul style="list-style-type: none"> <input type="radio"/> Independent <input type="radio"/> Partially dependent <input type="radio"/> Totally dependent
<p>Does the patient have psychosocial and/or substance abuse issues?</p> <ul style="list-style-type: none"> <input type="radio"/> Absent - no psychosocial and/or substance issues <input type="radio"/> Addressed – psychosocial and/or substance issues present but addressed 	
<p>Will any of the following be used?</p> <ul style="list-style-type: none"> <input type="radio"/> Allograft <input type="radio"/> Autograft – patient's own tissue <input type="radio"/> BMP – Bone Morphogenetic Protein <input type="radio"/> Stem Cells <input type="radio"/> None of the above <p>Vendor: _____</p> <p>Name/Type of Product: _____</p>	<p>Will a co-surgeon or assistant be utilized?</p> <ul style="list-style-type: none"> <input type="radio"/> Orthopedic <input type="radio"/> Physician's Assistant/Nurse Practitioner <input type="radio"/> RN Surgical Assist <input type="radio"/> Other: _____ <input type="radio"/> No planned co-surgeon or assistant
<p>Other Products Intended to be Used:</p>	
<p>Manufacturer:</p>	
<p>Product Line:</p>	
<p>NOTE: Please include imaging reports, surgical plan, and clinical documentation of ALL conservative therapies that have been attempted as well as the duration of each type of conservative treatment.</p>	