



Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association



# JOINT AND SPINE PROCEDURES AUTHORIZATION REQUEST FORM

Utilization management toll-free phone: 1-833-217-9670  
Utilization management local phone: 313-908-6040  
Utilization management fax: 313-879-5509

<b>Today's date (mm/dd/yyyy):</b> ___ / ___ / ____
<b>Provider contact name:</b>
<b>Provider contact phone:</b>
<b>Provider contact fax:</b>
<b>Provider contact email:</b>
<b>Provider name:</b>
<b>Provider TIN:</b>
<b>Provider NPI:</b>
<b>Practice/group name:</b>
<b>Provider physical address:</b>
<b>Provider mailing address (if different):</b>

<b>Member name:</b>
<b>Date of birth (mm/dd/yyyy):</b> ___ / ___ / ____
<b>Member ID (including any alpha prefix):</b>
<b>Health plan:</b>
<b>Notification method preference:</b> <input type="checkbox"/> Postal mail <input type="checkbox"/> Fax
<b>Mailing address or fax number:</b>
<b>Notes:</b>

<b>Requested procedure:</b>	<b>Anticipated surgery date (mm/dd/yyyy)</b>
<b>CPT/HCPCS or ICD procedure code(s):</b>	
<b>Diagnosis code(s):</b>	
<b>Facility setting:</b> <input type="checkbox"/> Provider office <input type="checkbox"/> Outpatient facility <input type="checkbox"/> Inpatient hospital <input type="checkbox"/> Ambulatory surgical center	
<b>Facility name:</b>	<b>Facility contact name:</b>
<b>Facility TIN:</b>	<b>Facility contact phone:</b>
<b>Facility NPI:</b>	<b>Facility contact fax:</b>
<b>Facility physical address:</b>	<b>Facility mailing address (if different):</b>

**Case urgency**

- Standard       Expedited

In keeping with guidelines from the National Committee for Quality Assurance and Centers for Medicare & Medicaid Services, prior authorization requests qualify for expedited review when the standard review time frame could do one of the following:

- Seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state.
- In the opinion of a practitioner with knowledge of the member's medical or behavioral health condition, subject the member to adverse health consequences without the care or treatment that is the subject of the request.

**Patient's height:** \_\_\_\_\_

**Patient's weight:** \_\_\_\_\_

**Patient's BMI:** \_\_\_\_\_

**Does the patient have any of the following comorbidities?  
Select all that apply.**

- Diabetes that requires medication or insulin (Type I or Type II) AIC Level: \_\_\_\_\_
- Hypertension requiring medication
- Previous cardiac event
- Congestive heart failure
- Dyspnea
- Current smoker within past 12 months
- History of severe COPD
- Dialysis
- Acute renal failure
- Ascites within past 30 days
- Steroid use for chronic condition
- Disseminated cancer
- None of the above

**NOTE:** For policies with smoking and BMI criteria, the requesting provider must include signed documentation stating that they have discussed the risks and benefits of the procedure related to smoking and elevated BMI, as appropriate.

**Patient's activities of daily living (ADL) functional status:**

- Independent
- Partially independent
- Totally dependent

**Does the patient have psychosocial and/or substance use issues?**

- Absent – no psychosocial and/or substance use issues
- Address – psychosocial and/or substance use issues present but addressed

**Will any of the following be used?**

- Allograft
- Autograft – patient's own tissue
- Bone Morphogenetic Protein
- Stem cells
- None of the above

**If requesting procedure code \*20930, please indicate tissue type:**

Vendor: \_\_\_\_\_

Name/type of product: \_\_\_\_\_

**Will a co-surgeon or assistant be utilized?**

- Orthopedic
- Physician's Assistant/Nurse Practitioner
- RN Surgical Assistant
- Other: \_\_\_\_\_
- No planned co-surgeon or assistant

**Other products intended to be used:**

**Manufacturer:** \_\_\_\_\_

**Product line:** \_\_\_\_\_

**NOTE:** 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.

**Form completed by:** \_\_\_\_\_

**Date:** \_\_\_\_\_

\*CPT Copyright 2022 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.