Blue Cross Blue Shield Blue Care Network of Michigan

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

TurningPoint Healthcare Solutions

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

Today's date and time:	**Member name:**
Provider contact name:	**Date of birth:**
Provider contact phone:	**Member ID (including any alpha prefix):**
Provider contact fax:	**Health plan:**
Provider name:	**Notification method preference:** ◯ **Postal mail** ◯ **Fax** **Please provide mailing address or fax number.**
Provider TIN:	
Provider NPI:	
Practice/group name:	
Provider physical address:	**Notes:**
Provider mailing address (if different):	

Requested procedure:	**Anticipated surgery date:**
CPT/HCPCS or ICD procedure code(s):	
Diagnosis code(s):	
Facility setting: ◯ **Inpatient hospital** ◯ **Outpatient** ◯ **Provider Office** ◯ **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: _____**

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

- ☐ Diabetes that requires medication or insulin (Type I or Type II)
  A1C 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

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

- ○ Independent
- ○ Partially dependent
- ○ Totally dependent

What is the patient's current health status?

- ○ Normal healthy patient
- ○ Mild or moderate disease that does not limit activity (ex: controlled HTN or DM, mild obesity)
- ○ Severe disease that limits activity (ex: controlled CHF, history of MI, uncontrolled HTN or DM)
- ○ Severe life-threatening disease (ex: symptomatic CHF or COPD, renal failure, unstable angina)

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

- ○ Absent - no psychosocial and/or substance use issues
- ○ Addressed – 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: 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.

Completed by: **Date:**