JOINT AND SPINE AUTHORIZATION REQUEST FORM

Utilization Management local phone: 866-747-0586
Utilization Management fax: 423-800-5302

Please Note: For non-urgent joint and spine requests, please complete the form and submit with all appropriate and relevant medical records (imaging, office visit notes, attempted conservative treatments, etc.). Failure to submit appropriate relevant medical records may result in determination delays and denials.

*Requests can be submitted online at any time through Availity.com.
*Contact the eBusiness Marketing team for all your Availity® registration and training needs by calling 423-535-5717 option 2 or emailing eBusiness_marketing@bcbst.com.

Today's date (mm/dd/yyyy): __ / __ / ____

MEMBER INFORMATION		
Member name:		**Date of birth (mm/dd/yyyy): __ / __ / ____**
Member ID:	**Suffix:**	**Health plan:**

RENDERING PROVIDER INFORMATION	
Contact name:	
Contact phone:	**Contact fax:**
Provider name:	
Provider NPI:	**Provider Mailing address or fax number:**
Provider TIN:	
BCBSTN Provider ID:	
Practice/group name:	
Notes:	**Provider physical address:**
	Notification method preference: ☐ Postal mail ☐ Fax

Where will the procedure take place?

◯ Provider office ◯ Outpatient ◯ Observation ◯ Inpatient hospital

Facility name:	**BCBSTN Provider ID:**
Facility TIN:	**Facility contact name:**

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JOINT AND SPINE INTAKE FORM
AUTHORIZATION REQUEST FORM

Utilization management local phone: 866-747-0586
Utilization management fax: 423-800-5302

Facility NPI:	**Facility contact phone:**
Facility physical address:	**Facility contact fax:**

Requested procedure		**Anticipated date of service (mm/dd/yyyy): __ / __ / ____**
CPT/HCPCS or ICD Procedure Code(s):		
Primary Diagnosis code:		**Additional Diagnosis code(s):**
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)
  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

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

- ○ Absent - no psychosocial and/or substance issues
- ○ Addressed – psychosocial and/or substance issues present but addressed

Will any of the following be used?

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

If CPT 20930 is being requested, 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 Assist
- ○ Other:_____
- ○ No planned co-surgeon or assistant

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Other Products Intended to be Used:
Manufacturer: **Product Line:**

By submitting this request, you are confirming that you have provided all clinical information available pertinent to this request and you are requesting the decision be made based on information provided in your submission.	
Form completed by:	**Date:**

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