AUTHORIZATION REQUEST FORM

Utilization Management Fax: (423) 800-5302

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

Member Name:	
Date of Birth:	
Member ID (including any alpha prefix):	**ID Suffix:**
Health Plan:	
Notification Method Preference: ☐ Fax ☐ Postal Mail *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: ☐ **In-Office**	☐ **Outpatient**	☐ **Observation**	☐ **Inpatient Hospital**
Facility Name:		**Facility Contact Name:**	
Facility TIN:		**Facility Contact Phone:**	
BCBSTN Facility ID:	**Facility NPI:**	**Facility Contact Fax:**	
Facility Physical Address:		**Facility Mailing Address (if different):**	

Patient's Height: __________	**Patient's Weight:** _________	**Patient's BMI:** _________

Does the patient have any of the following co-morbidities? 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 which 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 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

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

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.