SPINE SURGERY CLINICAL WORKSHEET

For NON-URGENT requests, please fax this completed document along with medical records, imaging, tests, etc. **MEDICAL RECORDS ARE REQUIRED WITH THIS FORM.** Failure to provide all relevant information may delay the determination. Phone and fax numbers can be found on eviCore.com under the Guidelines and Fax Forms section. You may also log into the provider portal located on the site to submit an authorization request. **URGENT (same day) requests must be submitted by phone.**

Date: _____

Patient/ Member

First Name: _____ MI: ____ Last Name: _____

Date of Birth *(mm/dd/yyyy)*: _____ Gender: ☐ Male ☐ Female

Street Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

Home Phone Number: ( ) _____ Cell: ( ) _____ Preferred Contact: ☐ Home ☐ Cell

Health Plan Name: _____ Member ID: _____ Group ID: _____

Rendering Physician

First Name: _____ Last Name: _____

Primary Specialty: _____ NPI: _____ TIN: _____

Phone Number: ( ) - _____ Fax Number: ( ) - _____

Street Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

Office Contact: _____ Ext: _____ Email: _____

Facility/Site of Service

Group/Site Name: _____

Primary Specialty: _____ NPI: _____ TIN: _____

Phone Number: ( ) - _____ Fax Number: (7==) - _____

Street Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

Office Contact: _____ Ext: _____ Email: _____

Clinical Information

Anticipated Date of Service *(mm/dd/yyyy)*: _____

Site of Service: ☐ Office ☐ Outpatient Hospital ☐ Inpatient ☐ Ambulatory Surgical Center

CPT Codes:

Code	**Units** (if > 1)	**Level** (i.e. C4-C5)	**Left**	**Right**

Diagnoses:

ICD-10 Code:		**ICD-10 Code:**	
ICD-10 Code:		**ICD-10 Code:**	
ICD-10 Code:		**ICD-10 Code:**	

MEDICAL RECORDS ARE REQUIRED WITH THIS FORM. Please provide medical documentation including but not limited to: Signs/Symptoms, date of first office visit related to this condition and/or after symptoms began, last office visit including re-evaluation, physical exam findings, previous medical history, duration and type of physician-directed treatment, outcome(s) of prior surgical/non-surgical physician-directed treatment and prior surgical/non-surgical interventions, results of relevant prior imaging related to the request including the radiologist's report of advanced diagnostic imaging studies and the results of the Oswestry Disability Index (ODI), SF-36 or modified Japanese Orthopaedic Association (mJOA) scores as required by the client's Spine Surgery clinical criteria.

Please note this document is to be used as a tool to assist with prior authorization requests. Providing all of the information listed on this tool in no way grants approval of the requested procedure(s). All requests are subject to a review for Medical Necessity, at which time a determination is made. Submission of this form, without medical records, will limit our ability to administer a determination.