Innovative Care Management

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Healthcare savings and satisfaction through innovation and respect.

Please complete and FAX this questionnaire with the following clinical information to 503-654-8570:

1. *Most recent **History & Physical***.
2. Most recent ***office visit note(s)*** documenting symptoms and conservative therapy.
3. Most recent ***imaging reports***, i.e., X-ray, MRI, CT.

Note: Please do not resend clinical if already submitted by separate fax.

Patient Name: ______________________________ DOB: ____________________

Employer/Plan Name: __________________________ Plan ID: ____________________

Submitted By: ____________________ Phone: ______________ Fax: ____________

Physician: ____________________ Phone: ______________ Fax: ____________

Facility: ______________________________ Phone: ____________________

Please indicate the ***date of service*** for this pending request: ________________ or ❑ Not Scheduled

❑ Inpatient ❑ Outpatient

CPT code(s): ______________________________ ICD10 code(s): ____________________

Please indicate the ***level(s)*** of this spinal surgery (e.g. C2-C3): ______________________________

As part of the review of the request, **we require documentation of the type of graft material** to be used during the procedure. Please identify the type of graft material(s) to be used below. If a combination of materials are being used, please check all appropriate boxes and fill out accompanying fields.

❑ **Synthetic Graft Material:**

Including, but not limited to, bone morphogenic protein, bone void fillers, ceramic or polymer based, etc.

Product name(s): ______________________________ Manufacturer(s): ____________________

❑ **Allograft:**

Type(s): ______________________________

e.g. cadaver, demineralized bone matrix, cancellous, morselized bone, etc.

Product name(s): ______________________________ Manufacturer(s): ____________________

❑ **Autograft (Autologous) – Patient's own bone**

Please note: if a different or additional graft materials not preauthorized are used at the time of surgery, the additional graft material(s) may be reviewed for medical necessity retrospectively and applicable plan language (including Experimental & Investigational exclusions) will be considered prior to claims payment. We *strongly* encourage pre-service review of all graft materials.