



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 for the primary procedure.

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

Our records indicate there has been a request for preauthorization for a back procedure which requires we determine if Intraoperative Nerve Monitoring will be performed.

Will Intraoperative Nerve Monitoring (IONM) be performed during this procedure?

- [] Yes (Continue) [] No (Stop here and return form)

Will the requesting surgeon be performing Intraoperative Nerve Monitoring (IONM)? [] Yes [] No

If no, will another entity be performing Intraoperative Nerve Monitoring (IONM)? [] Yes [] No

NOTE: If the requesting surgeon will not be billing for IONM, but the outside entity will be, they will need to obtain preauthorization for the procedure.

If the requesting surgeon will be performing IONM, what type of nerve monitoring will be conducted:

Evoked Potentials - [] Yes [] No

CPT Codes: _____

Electromyographic - EMG monitoring - [] Yes [] No

CPT Codes: _____

Electroencephalographic - EEG monitoring - [] Yes [] No

CPT Codes: _____

Please fax this form to us at 503-654-8570 and include clinical information documenting the use of IONM.