

All fields are REQUIRED unless otherwise noted. Incomplete or illegible handwritten requests will be returned.

Note: Use of this request document will require submission via fax, mail, or the electronic submission of Medical Documentation (esMD). To save time, use the myCGS Web portal to submit your request, upload your documentation electronically, track the status of your request, and receive a quicker response.

Request Type

Expedited Reason

Note: Provide reason for expediting request if Expedited Initial or Expedited Resubmission Request Type is selected above.

Requested HCPCS (maximum of 4)

Primary Diagnosis Code

Type of Bill

Date of Service

UTN

Only required for Resubmissions & Expedited Resubmissions. Enter the UTN of most recent submission.

FACILITY INFORMATION

Facility Name

PTAN

NPI

Region

Note: Facility information should be the Hospital Outpatient Department information.

Fax Number

Note: If submitting by fax, fax number is required. The fax number must be the fax number of the Hospital Outpatient Department. If submitting by mail or esMD, fax number is optional. If you want to also receive the decision letter via fax, provide a fax number. A decision letter will be sent by mail to the provider address on file.

BENEFICIARY INFORMATION (only one beneficiary per form)

Beneficiary Name

Medicare ID

ATTENDING PHYSICIAN INFORMATION

Physician Name

NPI

Fax Number

Address

REQUESTOR INFORMATION

Requestor Name

Email

Date

Phone Number

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JURISDICTION 15 PART A

PRIOR AUTHORIZATION OPD: CERVICAL FUSION WITH DISC REMOVAL

Please answer and follow the instructions for each question below.

QUESTIONS

- Q1.** Does the beneficiary have any of the following conditions? **Yes or No**
- Cervical Spinal Stenosis causing neurological deficit
 - Cervical instability
 - Symptomatic pseudoarthrosis
 - Symptomatic adjacent or same segment stenosis following prior spinal surgery in the absence of spondylolisthesis
 - Trauma
 - Spinal tumor, primary or metastases
 - Spinal infection
 - Clinically significant deformity of the spine (kyphosis, head-drop syndrome, post-laminectomy deformity)
 - Emergency Situation

Note: If the answer is No, the procedure may not be considered medically necessary.

Comments:

- Q2.** Do the medical records include radiologic evidence or physician interpretation to support diagnosis? **Yes or No**

Note: If answer is No, the procedure may not be considered medically necessary.

Comments:

- Q3.** Have conservative treatments been attempted? **Yes or No**
- Exercise
 - Pharmacological therapy
 - Physical Therapy
 - Activity/Lifestyle modification

Note: If answer is No, the procedure may not be considered medically necessary.

Comments:

- Q4.** Does the medical record document outline symptoms interfering with ADLs which correlate with diagnosis/level affected? **Yes or No**

Note: If answer is No, the procedure may not be considered medically necessary.

Comments:

Note: Attach supporting documentation for condition and associated symptoms, rationale for treatment procedure, etc. and/or comment.

DOCUMENTATION

Condition and Associated Symptoms/ Rationale for Treatment Procedure