Spinal Surgery and Fusion Authorization Form

Refer to the back of the patient's ID card under the heading Prior Authorization for the appropriate contact information.

Purpose of this form
You can use this form to initiate your precertification request. The form will also help you know what supporting documentation is needed for GEHA to review your request.

You can find our coverage policies at **Provider resources**. These will allow you to see the criteria used to determine medical necessity and procedures that are not allowable.

For us to review your request properly and to avoid delay, you must complete all sections of the form and provide the necessary supporting documentation. If you have questions about the form or need help, you can speak with a surgical specialist at **800.821.6136, ext. 3100**.

After you have completed the form
Preauthorization reviews are completed within 15 days from the time that we receive complete information. Please allow for this time when scheduling the procedure. We are not able to consider a request "urgent" unless waiting the regular time limit for authorization could seriously jeopardize a patient's life, health or ability to regain maximum function. Post-service reviews are completed within 30 days.

Spinal Surgery and Fusion Authorization Form

Refer to the back of the patient's ID card under the heading Prior Authorization for the appropriate contact information.

Date of request: ____________________________

Patient name: ____________________________ Phone: ____________________________

Preferred pronouns: ____________________________ (optional)

ID number: ____________________________ Date of birth: ____________________

Member address: ____

____

DX: ____________________________ ICD-10 code: ____________________

Physician: ____

Tax ID: ____________________________

Address: ____

____

Contact: ____

Phone: ____________________________ Fax: ____________________________

Facility: ____

Tax ID: ____________________________

Address: ____

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Contact: ____

Phone: ____________________________ Fax: ____________________________

Surgery information:

Check one: ☐ Inpatient **OR** ☐ Outpatient Date of surgery: ____________________

Surgery to be performed: ____

Surgical levels: ____________________________ ☐ Right ☐ Left ☐ Bilateral

List **ALL** CPT codes you will be using. All codes are subject for review regardless if requested pre or post service. ____

____

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If the surgery includes any of the below, please complete ALL requested information:

	Device name	Brand	Model number
Artificial disc			
Fusion Enhancement/Grafting (e.g., Autograft, Allograft, DBM, BMP)			
Hardware/Implantable (e.g., cages, spacers)			

	Anticipated percentage of excision
Facet (e.g., Planned excision ≥ 50% of the facets bilaterally, Planned excision ≥ 75% of a single facet)	
Pars interarticularis excision and/or Pars fracture present	
Bilateral transverse processes	
Pedicle (e.g., unilateral or bilateral)	
Vertebral body (Planned excision ≥ 50% of the vertebral body)	

Please list all conservative treatments with date(s) (medications-prescription and OTC, physical therapy, chiropractic care, injections, etc.): ______________________________________

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Additional exam testing (e.g., FABER, Spurling's, Straight leg test, range of motion, muscle strength etc.): ____

____

____

Date of last imaging related to this procedure: ____________________________________

The following list of codes are intended for reference purposes only, is NOT an all-inclusive code listing, and does not imply that the service is covered or non-covered.

20930	22585	22856	63076	63282
20931	22586	22857	63077	63283
20936	22590	22858	63078	63285
20937	22595	22859	63081	63286
20939	22600	22861	63082	63287
22100	22610	22862	63085	63290
22101	22612	22864	63086	63295
22102	22614	22865	63087	63300
22103	22630	22867	63088	63301
22110	22632	22868	63090	63302
22112	22633	22869	63091	63303
22114	22634	22870	63101	63304
22116	27279	22899	63102	63306
22206	27280	63001	63103	63308
22207	22800	63003	63172	0098T
22208	22802	63005	63173	0375T
22210	22804	63011	63185	0309T
22212	22808	63012	63190	0164T
22214	22810	63015	63191	0095T
22216	22812	63016	63197	
22220	22818	63017	63200	
22222	22819	63030	63250	
22224	22830	63035	63251	
22510	22840	63040	63252	
22511	22841	63042	63265	
22512	22842	63043	63266	
22513	22843	63044	63267	
22514	22844	63045	63268	
22515	22845	63047	63270	
22532	22846	63048	63271	22867
22533	22847	63050	63272	22868
22534	22848	63051	63273	22869
22548	22849	63055	63275	0163T
22551	22850	63056	63276	0165T
22552	22852	63057	63277	0213T
22554	22853	63064	63278	0214T
22556	22854	63066	63280	0274T
22558	22855	63075	63281	0275T

IMPORTANT: Submit letter of medical necessity, office notes and diagnostic tests (X-ray, MRI, CT, etc.). Fax completed form and supporting documents to GEHA at 816.257.3515 or 816.257.3255, or email caremanagementsurgery@geha.com.

Important information regarding Turn Around Time

Our reviews are completed within **15 days** from the time that we receive complete information. Please allow for this time when scheduling the procedure. We are not able to consider a request "urgent" unless waiting the regular time limit for authorization could seriously jeopardize a patient's life, health or ability to regain maximum function.

Any additional procedure submitted within a claim for surgical services **not prior authorized** will be subject to review for medical necessity upon GEHA's receipt of the claim. Please include an op report, letter of medical necessity, office notes and diagnostic test (X-ray, MRI, CT, etc.). Fax completed form and supporting documents to GEHA at 816.257.3515 or 816.257.3255, or email **caremanagementsurgery@geha.com**.

Questions: Call GEHA at 800.821.6136, ext. 3100

Payable benefits are subject to the terms and conditions of the Health Benefit Plan.