



Prior Authorization Form

Please Fax To (952)853-8713 For Questions Call (952)883-5724

Spinal Fusion for Lumbar Back Pain

Patient and Vendor information	
Patient Name: _____	Hospital: _____
HealthPartners ID #: _____	Tax ID#: _____
DOB: _____	Phone #: _____
	Fax #: _____
Form Completed By: _____	

Spine Surgeon: _____

Diagnosis: _____ ICD 9 code: _____

Procedure (CPT) code (s): _____

Procedure (s) to be performed: _____

Indicate the number of levels to be fused: _____

Please submit all of the following pertinent medical record documentation for the condition being treated:

1. Documentation of all of the following:
 - Visit summary notes from a Designated Medical Spine Center (MSC); and
 - Date of onset of unremitting pain and disability that has been refractory to a course of intensive conservative physical therapy for at least 8 weeks.
2. Dated Oswestry Disability Index (ODI) scores from the first and last therapy visits of the conservative therapy course.
3. Pre-surgical evaluation by the operating surgeon, including completed ODI evaluation form indicating level of continued disability.
4. Radiographic report(s) documenting (plain radiographs, MRI/CT scans) spinal instability.
5. Preoperative psychological evaluation from a licensed mental health professional, who has working knowledge of psychological issues associated with chronic pain.
6. Documentation that the patient was offered decision support.