



Spine Surgery Information Request Form

This form is used for UnitedHealthcare commercial members only. Medicare, Medicaid, FHP, or SCHP have their own specific requirements; please do not use this form.

Please fax the requested information to: 800-628-0654 promptly, as an accurate coverage decision cannot be made without this information. If you have any questions, or if this request is related to an emergent request for surgery, please call 877-842-3210. Thank you.

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| To: UnitedHealthcare | From: |
| Fax: 1-800-628-0654 | Fax: |
| Service Reference Number (Srn): | Phone: |
| | Pages (Including Cover): |
| Notification needs to be completed and Service Reference Number obtained prior to faxing this form. | |

Certain devices and surgical techniques require clinical review to determine whether they are covered by the member's policy, and if their utilization is in accordance with FDA-approved indications. Please provide the following information to assist us in determining coverage of your patient's planned procedure:

- ☐ COMPLETED SPINE SURGERY INFORMATION REQUEST FORM (ATTACHED).
- ☐ CLINICAL RECORDS, INCLUDING PATIENT HISTORY AND PROGRESS NOTES.
- ☐ RESULTS OF CONSERVATIVE CARE.
- ☐ RADIOLOGY REPORTS (X-RAYS/MRI).

You may view UnitedHealthcare policies in detail at:

UnitedHealthcareOnline.com > Policies and Protocols > Medical and Drug Policies.

NOTE: **IF REQUESTED INFORMATION IS INCOMPLETE, PAYMENT FOR THE CLAIM MAY BE DENIED.**

Completion of the notification process is not a guarantee of claims payment. Claims payment is subject to member eligibility, benefits and application of coverage as outlined in the member's coverage documents.

CONFIDENTIALITY NOTICE: Information accompanying this fax is considered to be UnitedHealthcare's confidential and/or proprietary business information. This information may be used only by the person or entity to which it is addressed. Such recipient shall be liable for using and protecting UnitedHealthcare's information from further disclosure or misuse, consistent with applicable contract and/or law. The information you have received may contain protected health information (PHI) and must be handled according to applicable state and federal laws, including, but not limited to Health Insurance Portability and Accountability Act (HIPAA). Individuals who misuse such information may be subject to both civil and criminal penalties. If you believe you received this information in error, please contact the sender immediately.

CLINICIAN IS REQUIRED TO COMPLETE THIS PORTION OF THE FORM

NOTE: This form is not for use for members of Medicare (including Secure Horizons/AARP), Medicaid, FHP, or SCHP plans.

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| Patient's Full Name: | Date of Birth: |
| Member ID: | Person completing the form: |
| Patient's Phone: | Phone : |
| Spine level(s): | <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Observation |

1. WHICH OF THE FOLLOWING SPINE FUSION TECHNIQUES WILL YOU BE USING? PLEASE INDICATE ALL TECHNIQUES.

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| <input type="checkbox"/> ANNULOPLASTY | <input type="checkbox"/> STANDARD ANTERIOR LUMBAR INTERBODY FUSION (ALIF) |
| <input type="checkbox"/> AXIAL LUMBAR INTERBODY FUSION (AxialLIF) | <input type="checkbox"/> STANDARD POSTERIOR LUMBAR INTERBODY FUSION (PLIF) |
| <input type="checkbox"/> CERVICAL INTERBODY FUSION | <input type="checkbox"/> TRANSFORAMINAL LUMBAR INTERBODY FUSION (TLIF) |
| <input type="checkbox"/> DIRECT LATERAL INTERBODY FUSION (DLIF) | <input type="checkbox"/> TRANSFORAMINAL LUMBAR INTERBODY FUSION WITH |
| <input type="checkbox"/> ENDOSCOPIC LUMBAR FUSION | ENDOSCOPY VISUALIZATION (such as a percutaneous incision with |
| <input type="checkbox"/> EXTREME LATERAL INTERBODY FUSION (XLIF) | video visualization) |
| <input type="checkbox"/> FACET FUSION WITHOUT DECOMPRESSION | <input type="checkbox"/> PERCUTANEOUS ENDOSCOPIC DISCECTOMY WITH OR WITHOUT LASER |
| <input type="checkbox"/> FACET FUSION WITH DECOMPRESSION | <input type="checkbox"/> PERCUTANEOUS LASER DISC DECOMPRESSION |
| <input type="checkbox"/> GUIDED LATERAL INTERBODY FUSION (GLIF) | <input type="checkbox"/> NUCLEOPLASTY (PERCUTANEOUS DISC DECOMPRESSION) |
| <input type="checkbox"/> GUIDED OBLIQUE LATERAL INTERBODY FUSION (GOLIF) | <input type="checkbox"/> PERCUTANEOUS LUMBAR DISCECTOMY |
| <input type="checkbox"/> INTERLAMINAR LUMBAR INSTRUMENTED FUSION (ILIF) | <input type="checkbox"/> OTHER SPINAL FUSION TECHNIQUE: |
| <input type="checkbox"/> LAPAROSCOPIC ANTERIOR LUMBAR INTERBODY FUSION (LALIF) | |
| <input type="checkbox"/> POSTERIOR LUMBAR INTERBODY FUSION (PLIF) | |

2. WHICH OF THE FOLLOWING OTHER SPINE SURGERY TECHNIQUES WILL YOU BE USING? PLEASE INDICATE ALL TECHNIQUES.

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| <input type="checkbox"/> ACCURASCOPE | <input type="checkbox"/> TOTAL ARTIFICIAL DISC REPLACEMENT |
| <input type="checkbox"/> DISCECTOMY | PLEASE INDICATE WHICH OF THE FOLLOWING: |
| <input type="checkbox"/> DSS BRAND STABILIZATION SYSTEM | <input type="checkbox"/> CERVICAL 1 LEVEL <input type="checkbox"/> LUMBAR |
| <input type="checkbox"/> DYNESYS® DYNAMIC STABILIZATION SYSTEM | <input type="checkbox"/> CERVICAL 2 CONTIGUOUS LEVELS <input type="checkbox"/> ARTIFICIAL DISC |
| <input type="checkbox"/> FORAMINOTOMY | <input type="checkbox"/> CERVICAL 2 NON CONTIGUOUS LEVELS <input type="checkbox"/> COMBINED WITH FUSION |
| <input type="checkbox"/> LAMINECTOMY | MUST PROVIDE THE BRAND NAME OF ARTIFICIAL DISC: |
| <input type="checkbox"/> LAMINOTOMY | |
| <input type="checkbox"/> MICRODISCECTOMY | |
| <input type="checkbox"/> IMAGE-GUIDED MINIMALLY INVASIVE LUMBAR | <input type="checkbox"/> TOTAL FACET JOINT ARTHROPLASTY |
| DECOMPRESSION (MILD®) | <input type="checkbox"/> X-STOP PRODUCT |
| <input type="checkbox"/> PERCUTANEOUS SACRAL AUGMENTATION (SACROPLASTY) | <input type="checkbox"/> INTERSPINOUS FIXATION DEVICE (E.G. COFLEX-F DEVICE) |
| <input type="checkbox"/> METRX MICRODISCECTOMY SYSTEM WITH VIDEO | <input type="checkbox"/> OTHER SPINE STABILIZATION TECHNIQUE/SYSTEM: |
| VISUALIZATION | |
| <input type="checkbox"/> METRX MICRODISCECTOMY SYSTEM WITH DIRECT | <input type="checkbox"/> OTHER SPINAL DECOMPRESSION PROCEDURE |
| VISUALIZATION | |

3. WHICH OF THE FOLLOWING PRODUCTS WILL YOU BE USING? PLEASE INDICATE ALL PRODUCTS.

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| <input type="checkbox"/> NONE | <input type="checkbox"/> CERAMIC-BASED PRODUCTS; |
| <input type="checkbox"/> AUTOGRAFT | PLEASE INDICATE WHICH OF THE FOLLOWING: |
| <input type="checkbox"/> CADAVER ALLOGRAFT | <input type="checkbox"/> BETA TRICALCIUM PHOSPHATE (b-TCP) |
| <input type="checkbox"/> ANIMAL ALLOGRAFT | <input type="checkbox"/> OTHER: MUST PROVIDE THE BRAND NAME: |
| <input type="checkbox"/> DEMINERALIZED BONE MATRIX; | |
| PLEASE INDICATE WHICH OF THE FOLLOWING: | |
| <input type="checkbox"/> ALLOGRAFT DBM <input type="checkbox"/> SYNTHETIC DBM | |
| MUST PROVIDE THE BRAND NAME: | |
| <input type="checkbox"/> AMNIOTIC TISSUE MEMBRANE | <input type="checkbox"/> CELL-BASED PRODUCTS; |
| <input type="checkbox"/> BONE MORPHOGENETIC PROTEIN-7 (BMP-7) | PLEASE INDICATE WHICH OF THE FOLLOWING: |
| <input type="checkbox"/> BONE MORPHOGENETIC PROTEIN-2 (BMP-2); | <input type="checkbox"/> MESENCHYMAL STEM CELLS <input type="checkbox"/> OSTEOCEL |
| PLEASE INDICATE WHICH OF THE FOLLOWING: | <input type="checkbox"/> TRINITY EVOLUTION |
| <input type="checkbox"/> INFUSE™ BONE GRAFT/LT-CAGE LUMBAR TAPERED FUSION DEVICE | <input type="checkbox"/> INFUSE/MASTERGRAFT POSTEROLATERAL REVISION |
| <input type="checkbox"/> INFUSE™ BONE GRAFT/INTERFIX™ THREADED FUSION DEVICE | DEVICE SYSTEM |
| <input type="checkbox"/> INFUSE™ BONE GRAFT/INTER FIX™ RP THREADED FUSION DEVICE | <input type="checkbox"/> OPTIMESH |
| <input type="checkbox"/> OTHER CAGE TYPE (for example PEEK or other); | <input type="checkbox"/> PLATELET-RICH PLASMA (PRP) |
| MUST PROVIDE THE BRAND NAME | <input type="checkbox"/> OTHER PRODUCT(S); MUST PROVIDE THE BRAND NAME: |