Instrumented Spinal Surgery Checklist



This form must be filled ou only, and can take up to two		Prior authorization requ	ests are accepted from providers	
Patient name		Patient b	Patient birth date	
Patient PacificSource ID No				
Checklist				
Are you planning continuous In	traoperative Monitoring-IOM (9	5940-95941) with this su	rgery? Yes No	
If yes, IOM requires a separate 1 prior authorization request for	e prior authorization request. <i>Exa</i> r <i>IOM</i> .	ample: 1 prior authorizatio	on request for the surgery and	
Does the patient currently use	tobacco? Yes No It	previous tobacco user, c	uit date	
Note: A negative cotinine lev	el, per lab results, is required	before surgery can be a	uthorized.	
Treatment plan (include level	s)			
Does the procedure include the	e screws, rods, or cages?	es No		
Artificial disc (implant) hardv	vare information (screws, rods	s, and cages)		
CPT code	Brand/manufacturer	Descripti	on	
			on	
CPT code	Brand/manufacturer	Descripti	on	
If using an unlisted CPT code,	please indicate why			
Autograft to be used: CPT code	e Brand/manuf:	acturer	Description	
Allograft to be used: CPT code_	Brand/manuf	acturer	Description	
Has the patient received physic	cal therapy? Yes (from	to) No	
Has the patient received chirop	practic treatment? Yes (from	n to) No	
Note: Physical therapy and/o	or chiropractic clinical docume	ntation must accompa	ny this form.	
Name of medication attempted	d	Date patient started _	Date stopped	
Name of medication attempted	d	Date patient started		
Name of medication attempted	d	Date patient started		

Note: To review your request, we require a radiologist report, as well as a member medical history with onset of symptoms, treatment, and response to treatment. If we do not receive the required documents, we cannot make an appropriate determination, and we will return your request to your office.

This is not an inclusive list. **Most spine procedures are sent to an external specialist to review, and the prior authorization request may be extended to allow time for specialist review.** If this is the case, we may request an imaging disk.

If an external review is required to make an appropriate decision, please mail the imaging disk to: PacificSource, Attn. Health Services, PO Box 7068, Springfield, OR 97475.

Please fax this page and your completed Prior Authorization Request Form to Health Services, 541-225-3625.

Questions? Please call us toll-free at **888-691-8209**, TTY: 711. We accept all relay calls. You'll find the Prior Authorization Request Form at PacificSource.com/resources/documents-and-forms.