Aplos Health Plans Preauthorization Request Form

Submit completed forms and clinical information outlined below by fax to **515-328-6597, or** by secure email to **Aplos@innovativecare.com**.

"A claim involving urgent care is generally a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could **seriously jeopardize the life or health of the claimant** or the **ability of the claimant to regain maximum function;** or, in the opinion of the physician with knowledge of the claimant's medical condition, would subject the claimant to **severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim**."

❑ I certify that this request meets the above definition for Urgent processing according to the Department of Labor.

Patient Information		
Last Name	First Name	Date of Birth
Employer/Plan Name		Plan ID
Address, City, State, Zip		Phone
Subscriber Name (if different than patient)		Subscriber Relationship

Your Contact Information (Submitted by)		
Name	Phone	Fax
Email		

Provider Information	
Provider Name	Specialty
Phone	Fax
Provider Primary Address (include suite # if applicable)	NPI
	TIN
Facility Information	
Facility	
Phone	Fax
Facility Address (include suite # if applicable)	NPI
	TIN

See next page for service details

Back Injections Service Request

Date of Service_____ ❑ Not Scheduled

Please indicate the type of injection requested:

❑ Epidural Steroid Injection ❑ SI Joint Injection ❑ Medial Branch Block
❑ Facet Injection ❑ Trigger Point Injection ❑ Radiofrequency ablation (RFA)

Description of Service(s) Requested

*Note: If you are requesting authorization to separately bill **ultrasound/radiologic guidance, fluoroscopy, or epidurography**, please be advised that these services will need to be sent to a physician review for determination and will delay the processing of your request. If you are not separately billing for these codes, please do not include on this request form.*

CPT Code(s)	ICD Code(s)

Is the requested injection: ❑ Left ❑ Right ❑ Bilateral

Please indicate the **level(s)** of this injection (e.g. L5-S1): _____

Additional Information

Does the patient have any of the ***following conditions***?	❑ Coagulopathy ❑ Injection site infection ❑ Increased Intracranial pressure ❑ Epidural metastases ❑ Septicemia ❑ None of the above conditions
Has the patient been treated with **anti-inflammatory drugs**? (NSAIDS, etc.)	❑ Yes ❑ No How long? _____
Has the patient been treated with **conservative therapies**?	❑ Yes ***(indicate length of time in space)*** Physical therapy_____ Chiropractic_____ Activity modification_____ ❑ No
Has the patient had a prior spinal injection at this level?	❑ Yes ❑ No

Please provide the dates, levels, response, and duration for injections in the last 12 months:

Note: if this is the first injection, please check here: ❑

Date	Injection Type (e.g. facet, ESI, etc.)	Level(s)	Response (% relief)	Duration (week, month, etc)

Clinical Information: For General Preauthorization requests, please include the following information:

☐ **History & Physical** prior to initial injection

☐ Most recent **office visit note(s)** documenting care and noting specifics of above pertinent findings

☐ Most recent **imaging reports**, including MR or CT

☐ Any other **pertinent clinical information** that substantiates medical necessity for the requested service(s)

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