# 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**

| Joint Arthroplasty Service Request | | |
|---|---|---|
| Date of Service | | ❑ Not Scheduled |
| Type of Service | ❑ Inpatient | ❑ Outpatient |
| Description of Service(s) Requested. Please indicate the joint of this arthroplasty (e.g., left hip) | | |
| CPT Code(s) | ICD Code(s) | |

**Additional Information**

Is the planned procedure a custom joint replacement (implant individually manufactured for this patient)? ❑ Yes ❑ No

If yes, implant Product Name: _____

Manufacturer: _____

Is the planned procedure using a robotic or computer assist? ❑ Yes ❑ No

If yes, will it be billed separately? ❑ Yes ❑ No CPT code(s):_____

Name of procedure/system to be used (e.g. MAKOplasty):_____

Is the planned procedure using Patient-specific Instrumentation (individually manufactured for this patient)? ❑ Yes ❑ No

If yes, instrumentation product name: _____

Manufacturer:_____

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

☐ Most recent **History & Physical**

☐ Most recent **office visit note(s)** documenting symptoms and conservative therapy

☐ Related i**maging reports**, i.e, X-ray, MRI, CT

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

***Note:*** Please do not resend clinicals if already submitted by separate fax.

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- Fax **515-328-6597**