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

Spinal Fusion Service Request

Date of Service ❑ Not Scheduled	❑ Inpatient ❑ Outpatient

Description of Service(s) Requested, including level(s) of the spinal surgery (e.g. C2-C3):

CPT Code(s)	ICD Code(s)

Graft Material: ***We require documentation of the proposed type of graft material***. Please identify the type of graft material(s) to be used below. If a combination of materials will be used, please check all appropriate boxes and associated fields.

❑ **Synthetic Graft Material** e.g. bone morphogenic protein, bone void fillers, ceramic or polymer-based, etc.

Product Name(s):_____ Manufacturer(s):_____

❑ **Allograft** e.g. cadaver, demineralized bone matrix, cancellous, morselized bone, etc.

Type(s):_____

Product Name(s):_____ Manufacturer(s):_____

❑ **Autograft (Autologous)** – Patient's own bone

Please note: If different or additional graft material(s) not preauthorized are used at the time of surgery, the additional graft material(s) may be reviewed for medical necessity retrospectively and applicable plan language (including Experimental & Investigational exclusions) will be considered prior to claims payment. We ***strongly*** encourage pre-service review of all graft material.

Intraoperative Nerve Monitoring Service Request

Will Intraoperative Nerve Monitoring (IONM) be performed during this procedure: ❑ Yes ❑ No (If no, stop here and submit)

Will the **requesting surgeon** be performing Intraoperative Nerve Monitoring (IONM)? ❑ Yes ❑ No

If **yes**, what type of nerve monitoring (Evoked Potentials, Electromyographic-EMG Monitoring, EEG Monitoring, etc.):

CPT:_____ Description:_____

CPT:_____ Description:_____

CPT:_____ Description:_____

CPT:_____ Description:_____

If **no**, IONM Provider Name:_____ Phone:_____

Address:_____ Fax:_____

Note: If the requesting surgeon will not be billing for IONM, but an outside entity will be, the outside entity will need to obtain preauthorization for the IONM services.

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 as applicable
- ☐ Most recent **imaging reports**, e.g., X-ray, MRI, CT
- ☐ Related **Operative Reports**
- ☐ Any other **pertinent clinical information** that substantiates medical necessity for the requested service(s)

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- Secure email to Aplos@innovativecare.com
- Fax **515-328-6597**