



Please Note: For non-urgent joint and spine requests, please complete the form and submit with all appropriate and relevant medical records (imaging, office visit notes, attempted conservative treatments, etc.). Failure to submit appropriate relevant medical records may result in determination delays and denials.

*Requests can be submitted online at any time through [Availity.com](https://www.availity.com).

*Contact the eBusiness Marketing team for all your Availity® registration and training needs by calling 423-535-5717 option 2 or emailing eBusiness_marketing@bcbst.com.

Today's date (mm/dd/yyyy): __ / __ / ____

MEMBER INFORMATION

Member name:		Date of birth (mm/dd/yyyy): __ / __ / ____
Member ID:	Suffix:	Health plan:

RENDERING PROVIDER INFORMATION

Contact name:	
Contact phone:	Contact fax:
Provider name:	
Provider NPI:	Provider Mailing address or fax number:
Provider TIN:	
BCBSTN Provider ID:	
Practice/group name:	
Notes:	Provider physical address:
	Notification method preference: <input type="checkbox"/> Postal mail <input type="checkbox"/> Fax

Where will the procedure take place?

<input type="checkbox"/> Provider office <input type="checkbox"/> Outpatient <input type="checkbox"/> Observation <input type="checkbox"/> Inpatient hospital			
Facility name:		BCBSTN Provider ID:	
Facility TIN:		Facility contact name:	

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**JOINT AND SPINE INTAKE FORM
AUTHORIZATION REQUEST FORM**

Utilization management local phone: 866-747-0586
Utilization management fax: 423-800-5302

Facility NPI:	Facility contact phone:
Facility physical address:	Facility contact fax:

Requested procedure	Anticipated date of service (mm/dd/yyyy): __ / __ / __	
CPT/HCPCS or ICD Procedure Code(s):		
Primary Diagnosis code:	Additional Diagnosis code(s):	
Patient's height:	Patient's weight:	Patient's BMI:

<p>Does the patient have any of the following comorbidities? Select all that apply.</p> <ul style="list-style-type: none"> <input type="radio"/> Diabetes that requires medication or insulin (Type I or Type II) A1C Level: _____ <input type="radio"/> Hypertension requiring medication <input type="radio"/> Previous cardiac event <input type="radio"/> Congestive heart failure <input type="radio"/> Dyspnea <input type="radio"/> Current smoker within past 12 months <input type="radio"/> History of severe COPD <input type="radio"/> Dialysis <input type="radio"/> Acute renal failure <input type="radio"/> Ascites within past 30 days <input type="radio"/> Steroid use for chronic condition <input type="radio"/> Disseminated cancer <input type="radio"/> None of the above 	<p>Patient's Activities of Daily Living (ADL) Functional status:</p> <ul style="list-style-type: none"> <input type="radio"/> Independent <input type="radio"/> Partially dependent <input type="radio"/> Totally dependent
	<p>Does the patient have psychosocial and/or substance abuse issues?</p> <ul style="list-style-type: none"> <input type="radio"/> Absent - no psychosocial and/or substance issues <input type="radio"/> Addressed – psychosocial and/or substance issues present but addressed

<p>Will any of the following be used?</p> <ul style="list-style-type: none"> <input type="radio"/> Allograft <input type="radio"/> Autograft – patient's own tissue <input type="radio"/> BMP – Bone Morphogenetic Protein <input type="radio"/> Stem Cells <input type="radio"/> None of the above <p>If CPT 20930 is being requested, please indicate tissue type:</p> <p>Vendor: _____</p> <p>Name/Type of Product: _____</p>	<p>Will a co-surgeon or assistant be utilized?</p> <ul style="list-style-type: none"> <input type="radio"/> Orthopedic <input type="radio"/> Physician's Assistant/Nurse Practitioner <input type="radio"/> RN Surgical Assist <input type="radio"/> Other: _____ <input type="radio"/> No planned co-surgeon or assistant
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AUTHORIZATION REQUEST FORM**

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Utilization management fax: 423-800-5302

Other Products Intended to be Used:
Manufacturer:
Product Line:

By submitting this request, you are confirming that you have provided all clinical information available pertinent to this request and you are requesting the decision be made based on information provided in your submission.	
Form completed by:	Date:

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