



# Surgical Consult for Low Back Pain Prior Authorization Request

## Member Information

Member Name (please print)	Date of Birth	Member ID
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## Provider Information

Referring Provider	Tax ID	Fax	
Refer to Provider <i>(Name of Orthopedic Spine Surgeon/Neurosurgeon/Clinic)</i>	Phone	Fax	
Diagnosis	NPI	ICD-10	
Provider Contact Name	Phone	Fax	Request Date

Please submit clinical documentation to support medical necessity for requested item.

## Please indicate if any of the following are present:

<input type="checkbox"/> Fever	<input type="checkbox"/> Unexplained Weight Loss	<input type="checkbox"/> H/O Cancer
<input type="checkbox"/> Pain for more than 6 weeks	<input type="checkbox"/> Trauma	<input type="checkbox"/> IV Drug Use
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Prior Spine Surgery	<input type="checkbox"/> Neurodeficit
<input type="checkbox"/> Immunosuppression		

Please indicate the reason for requesting a surgical consult:

Patient has failed the following treatments:

<input type="checkbox"/> NSAIDs	<input type="checkbox"/> Spinal Injections	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Chiropractic Treatment
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Projected appointment date:

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**Please fax completed form to:** Group Health Cooperative of Eau Claire **Fax:** 715.552.7202