Priority Health

TurningPoint

AUTHORIZATION REQUEST FORM

Utilization Management Local Phone: (313) 221-5553
Utilization Management Toll Free Phone: (855) 511-0840
Utilization Management Local Fax: (313) 261-7199
Utilization Management Toll Free Fax: (833) 374-0036

***** Want to save time? Check out our new and improved provider portal. *****

Visit www.myturningpoint-healthcare.com to sign up for TurningPoint's Provider Portal in just a few clicks.

In most circumstances, portal cases are processed 1-2 days faster on average than a submission through phone or fax.

Today's Date & Time:	**Member Name:**
Provider Contact Name:	**Date of Birth:**
Provider Contact Phone:	**Member ID (including any alpha prefix):**
Provider Contact Fax:	**Health Plan:**
Provider Contact Email:	
Provider Name:	Notification Method Preference: ☐ Postal Mail ☐ Fax *Please be sure mailing address or fax number is provided. **Notes:**
Provider TIN:	
Provider NPI:	
Practice/Group Name:	
Provider Physical Address:	
Provider Mailing Address (if different):	

Facility Setting: ☐ **Inpatient Hospital** ☐ **Outpatient / Observation**	☐ **Ambulatory Surgical Center** ☐ **Provider Office**
Requested Procedure:	**Anticipated Surgery Date:**
CPT® / HCPCS or ICD Procedure Code(s):	
Diagnosis Code(s):	
Facility Name:	**Facility Contact Name:**
Facility TIN:	**Facility Contact Phone:**
Facility NPI:	**Facility Contact Fax:**
Facility Physical Address:	**Facility Mailing Address (if different):**

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Does the patient have any of the following co-morbidities? Select all that apply.

- Diabetes that requires medication or insulin (Type I or Type II)
  - A1C Level: _________
- Hypertension Requiring Medication
- Previous Cardiac Event
- Congestive Heart Failure
- Dyspnea
- Current Smoker Within Past 12 Months
- History of Severe COPD
- Dialysis
- Acute Renal Failure
- Ascites Within Past 30 Days
- Steroid Use for Chronic Condition
- Disseminated Cancer
- None of the Above

Patient's Body Mass Index (BMI):

Patient's Activities of Daily Living (ADL) Functional status:

- Independent
- Partially Dependent
- Totally Dependent

Does the patient have psychosocial and/or substance abuse issues?

- Absent - No Psychosocial and/or Substance Issues
- Addressed – Psychosocial and/or Substance Issues Present but Addressed

Will any of the following be used?

- Allograft
- Autograft – patient's own tissue
- Bone Morphogenetic Protein
- Stem cells
- None of the above

If requesting procedure code *20930, please indicate tissue type:

Vendor:

Name/type of product:

Will a co-surgeon or assistant be utilized?
(If yes, please provide the following information)

Yes No

Assistant Type:

Nurse Practitioner	Physician's Assistant
Registered Nurse	Assistant Surgeon
Co-Surgeon	Anesthesiologist

Assistant at Surgery Name:

Assistant at Surgery NPI:

Other Products Intended to be Used:

Manufacturer:

Product Line:

<u>NOTE:</u> Please include imaging reports, surgical plan, procedure notes and clinical documentation of ALL conservative therapies that have been attempted as well as the duration of each type of conservative treatment.

Form Completed By:	**Date:**