UnitedHealthcare®
Oxford

Spine Surgery Information Request Form

This form is used for UnitedHealthcare commercial members only. Medicare, Medicaid, FHP, or SCHP have their own specific requirements; please do not use this form.

Please fax the requested information to: 914-323-9266 promptly, as an accurate coverage decision cannot be made without this information. If you have any questions, or if this request is related to an emergent request for surgery, please call 1-888-381-3152. Thank you.

To: **UnitedHealthcare**	From:
Fax:**914-323-9266**	Fax:
Service Reference Number (Srn):	Phone:
	Pages (Including Cover):
Notification needs to be completed and Service Reference Number obtained prior to faxing this form.	

Certain devices and surgical techniques require clinical review to determine whether they are covered by the member's policy, and if their utilization is in accordance with FDA-approved indications. Please provide the following information to assist us in determining coverage of your patient's planned procedure:

- ☐ ☐ COMPLETED SPINE SURGERY INFORMATION REQUEST FORM (ATTACHED).
- ☐ ☐ CLINICAL RECORDS, INCLUDING PATIENT HISTORY AND PROGRESS NOTES.
- ☐ ☐ RESULTS OF CONSERVATIVE CARE.
- ☐ ☐ RADIOLOGY REPORTS (X-RAYS/MRI).

You may view UnitedHealthcare policies in detail at:
UnitedHealthcareOnline.com > Policies and Protocols > Medical and Drug Policies.

NOTE: **IF REQUESTED INFORMATION IS INCOMPLETE, PAYMENT FOR THE CLAIM MAY BE DENIED.** Completion of the notification process is not a guarantee of claims payment. Claims payment is subject to member eligibility, benefits and application of coverage as outlined in the member's coverage documents.

CLINICIAN IS REQUIRED TO COMPLETE THIS PORTION OF THE FORM

NOTE: This form is not for use for members of Medicare (including Secure Horizons/AARP), Medicaid, FHP, or SCHP plans.

Patient's Full Name:	Date of Birth:
Member ID:	Person completing the form:
Patient's Phone:	Phone :
Spine level(s):	☐ Inpatient ☐ Outpatient ☐ Observation

1. WHICH OF THE FOLLOWING SPINE FUSION TECHNIQUES WILL YOU BE USING? PLEASE INDICATE ALL TECHNIQUES.

- ☐ ANNULOPLASTY
- ☐ AXIAL LUMBAR INTERBODY FUSION (AxialLIF)
- ☐ CERVICAL INTERBODY FUSION
- ☐ DIRECT LATERAL INTERBODY FUSION (DLIF)
- ☐ ENDOSCOPIC LUMBAR FUSION
- ☐ EXTREME LATERAL INTERBODY FUSION (XLIF)
- ☐ FACET FUSION WITHOUT DECOMPRESSION
- ☐ FACET FUSION WITH DECOMPRESSION
- ☐ GUIDED LATERAL INTERBODY FUSION (GLIF)
- ☐ GUIDED OBLIQUE LATERAL INTERBODY FUSION (GOLIF)
- ☐ INTERLAMINAR LUMBAR INSTRUMENTED FUSION (ILIF)
- ☐ LAPAROSCOPIC ANTERIOR LUMBAR INTERBODY FUSION (LALIF)
- ☐ POSTERIOR LUMBER INTERBODY FUSION (PLIF)
- ☐ STANDARD ANTERIOR LUMBAR INTERBODY FUSION (ALIF)
- ☐ STANDARD POSTERIOR LUMBAR INTERBODY FUSION (PLIF)
- ☐ TRANSFORAMINAL LUMBAR INTERBODY FUSION (TLIF)
- ☐ TRANSFORAMINAL LUMBAR INTERBODY FUSION WITH ENDOSCOPY VISUALIZATION (such as a percutaneous incision with video visualization)
- ☐ PERCUTANEOUS ENDOSCOPIC DISCECTOMY WITH OR WITHOUT LASER
- ☐ PERCUTANEOUS LASER DISC DECOMPRESSION
- ☐ NUCLEOPLASTY (PERCUTANEOUS DISC DECOMPRESSION)
- ☐ PERCUTANEOUS LUMBAR DISCECTOMY
- ☐ OTHER SPINAL FUSION TECHNIQUE:

_____

2. WHICH OF THE FOLLOWING OTHER SPINE SURGERY TECHNIQUES WILL YOU BE USING? PLEASE INDICATE ALL TECHNIQUES.

- ☐ ACCURASCOPE
- ☐ DISCECTOMY
- ☐ DSS BRAND STABILIZATION SYSTEM
- ☐ DYNESYS® DYNAMIC STABILIZATION SYSTEM
- ☐ FORAMINOTOMY
- ☐ LAMINECTOMY
- ☐ LAMINOTOMY
- ☐ MICRODISCECTOMY
- ☐ IMAGE-GUIDED MINIMALLY INVASIVE LUMBAR DECOMPRESSION (MILD®)
- ☐ PERCUTANEOUS SACRAL AUGMENTATION (SACROPLASTY)
- ☐ METRX MICRODISCECTOMY SYSTEM WITH VIDEO VISUALIZATION
- ☐ METRX MICRODISCECTOMY SYSTEM WITH DIRECT VISUALIZATION
- ☐ TOTAL ARTIFICIAL DISC REPLACEMENT

PLEASE INDICATE WHICH OF THE FOLLOWING:

- ☐ CERVICAL 1 LEVEL
- ☐ CERVICAL 2 CONTIGUOUS LEVELS
- ☐ CERVICAL 2 NON CONTIGUOUS LEVELS
- ☐ LUMBAR
- ☐ ARTIFICIAL DISC COMBINED WITH FUSION

MUST PROVIDE THE BRAND NAME OF ARTIFICIAL DISC:

_____

- ☐ TOTAL FACET JOINT ARTHROPLASTY
- ☐ X-STOP PRODUCT
- ☐ INTERSPINOUS FIXATION DEVICE (E.G. COFLEX-F DEVICE)
- ☐ OTHER SPINE STABILIZATION TECHNIQUE/SYSTEM:

_____

- ☐ OTHER SPINAL DECOMPRESSION PROCEDURE

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3. WHICH OF THE FOLLOWING PRODUCTS WILL YOU BE USING? PLEASE INDICATE ALL PRODUCTS.

- ☐ NONE
- ☐ AUTOGRAFT
- ☐ CADAVER ALLOGRAFT
- ☐ ANIMAL ALLOGRAFT
- ☐ DEMINERALIZED BONE MATRIX;

PLEASE INDICATE WHICH OF THE FOLLOWING:

☐ ALLOGRAFT DBM ☐ SYNTHETIC DBM

MUST PROVIDE THE BRAND NAME: _____

- ☐ AMNIOTIC TISSUE MEMBRANE
- ☐ BONE MORPHOGENETIC PROTEIN-7 (BMP-7)
- ☐ BONE MORPHOGENETIC PROTEIN-2 (BMP-2);

PLEASE INDICATE WHICH OF THE FOLLOWING:

- ☐ INFUSE™ BONE GRAFT/LT-CAGE LUMBAR TAPERED FUSION DEVICE
- ☐ INFUSE™ BONE GRAFT/INTERFIX™ THREADED FUSION DEVICE
- ☐ INFUSE™ BONE GRAFT/INTER FIX™ RP THREADED FUSION DEVICE
- ☐ OTHER CAGE TYPE (for example PEEK or other);

MUST PROVIDE THE BRAND NAME _____

- ☐ CERAMIC-BASED PRODUCTS;

PLEASE INDICATE WHICH OF THE FOLLOWING:

- ☐ BETA TRICALCIUM PHOSPHATE (b-TCP)
- ☐ OTHER: **MUST PROVIDE THE BRAND NAME:**

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- ☐ CELL-BASED PRODUCTS;

PLEASE INDICATE WHICH OF THE FOLLOWING:

☐ MESENCHYMAL STEM CELLS ☐ OSTEOCEL ☐ TRINITY EVOLUTION

- ☐ INFUSE/MASTERGRAFT POSTEROLATERAL REVISION DEVICE SYSTEM
- ☐ OPTIMESH
- ☐ PLATELET-RICH PLASMA (PRP)
- ☐ OTHER PRODUCT(S); **MUST PROVIDE THE BRAND NAME:**

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 Please fax information for UnitedHealthcare employer group members to 914-323-9266.