Authorization Request Form - **Part 2**

Orthopedic Surgeries: Shoulder Arthroscopy

Complete and fax the clinical worksheet immediately following the Part 1 authorization request fax form, including any substantiating clinical documentation. Your responses enable faster processing of authorization requests and reduces the likelihood we may require you to submit additional clinical documentation to complete our review.

Please fill in each question option completely ⬭ → ⬬

Question 1

Which body site and side is symptomatic? (Required, fill in all that apply)

- ⬭ Left Shoulder
- ⬭ Right Shoulder

Question 2

How long has conservative care occurred within the past 12 months? (Required, fill in one option)

- ⬭ No conservative care occurred
- ⬭ Greater than 6 weeks
- ⬭ Greater than 12 weeks
- ⬭ None of the above

Question 3

What type of conservative care has been attempted? (Required, fill in all that apply)

- ⬭ Physical Therapy
- ⬭ Physician directed home exercise program
- ⬭ Medications
- ⬭ Injections
- ⬭ None of the above

Question 4

Does the surgeon have a preference for where the patient is discharged for post-acute care (if still appropriate at the time of discharge)? (Required, fill in one option)

- ⬭ Discharge home, no post-acute services required
- ⬭ Discharge home, outpatient Physical Therapy services required
- ⬭ Discharge home, Home Health Agency (HHA) services required
- ⬭ Discharge to Skilled Nursing Facility
- ⬭ No discharge preference indicated

Question 5

Did the patient's primary care physician provide preoperative medical clearance for this patient? (Optional, fill in one option)

- ⬭ Yes
- ⬭ No