AUTHORIZATION REQUEST FORM

Utilization Management Local Phone: (860) 955-4542
Utilization Management Toll Free Phone: (855) 577-2646
Utilization Management Fax: (866) 872-1379

TurningPoint requests a digital-first approach, with case submissions expected to be submitted through the portal whenever feasible. TurningPoint's provider portal can be accessed at: **myturningpoint-healthcare.com**.

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.
Provider TIN:	
Provider NPI:	
Practice/Group Name:	
Provider Physical Address:	
Provider Mailing Address (if different):	**Notes:**

Facility Setting:
☐ **Inpatient Hospital** ☐ **Outpatient / Observation** ☐ **Provider Office** ☐ **Ambulatory Surgical Center**

Facility Name:	**Facility Contact Name:**
Facility TIN:	**Facility Contact Phone:**
Facility NPI:	**Facility Contact Fax:**
Facility Physical Address:	**Facility Mailing Address (if different):**
Requested Procedure:	**Anticipated Surgery Date:**
CPT/HCPCS or ICD Procedure Code(s):	
Diagnosis Code(s):	

Patient's Height: _____	**Patient's Weight: _____**	**Patient's BMI: _____**

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 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:** 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:**