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### Pain Management Prior Authorization and Medical Necessity Determination Request Form

Please be advised that all questions must be answered completely. Failure to do so may delay a determination

**PATIENT INFORMATION:**

Member Name:

\_\_\_\_\_  
Last Name First Name

Primary Carrier/Member ID:

\_\_\_\_\_  
DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: Male Female

Subscriber Name: \_\_\_\_\_  
Last Name First Name

2° Carrier/Mem ID: \_\_\_\_\_

Is this service related to: MVA Worker's Compensation

**PHYSICIAN INFORMATION:**

Physician's Full Name and Office Location:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

TIN: \_\_\_\_\_

MD Signature: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

**PROCEDURE AND SITE OF SERVICE INFORMATION:**

Facility: \_\_\_\_\_  
Name Address TIN Phone#

Diagnosis Code(s): \_\_\_\_ . \_\_\_\_; \_\_\_\_ . \_\_\_\_; \_\_\_\_ . \_\_\_\_; Site of Service: Hosp Outpatient AmbSurg In-Office

Proposed Procedure(s): \_\_\_\_\_  
Planned Date of Service CPT Code(s) Including planned Imaging guidance Level(s)/Muscle Group(20552/3) Right/Left/Bilateral

Medication to be injected (all that apply): Steroid Anesthetic Agent Other \_\_\_\_ . If nerve destruction: RF Pulsed RF Other \_\_\_\_

**CLINICAL INFORMATION AND TREATMENT TO DATE: Office visit notes and recent diagnostic test results may be required**

Procedure Date	CPT Code	Level/Muscle Group	R/L/Bilat	% Improvement and Duration
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Total # of injections for this condition in past 12 months BY ALL physicians if > 3: \_\_\_\_\_

Patient History and Complaints and duration: \_\_\_\_\_

Physical Findings (Include Office Visit Date): \_\_\_\_\_

Imaging Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Imaging and Findings: \_\_\_\_\_

Therapy: PT Chiro Other \_\_\_\_\_ Pain Medication Rx Name(s): \_\_\_\_\_  
Start Date Mo/Yr. AND Pt Compliance AND % Improvement Name/Start Date Mo/Yr. AND % Improvement

Pain Medication cont.: \_\_\_\_\_  
Name/Start Date Mo/Yr. AND % Improvement

Follow-up Plan/Additional Info/Co-Morbidity: \_\_\_\_\_

Planned follow-up visit after procedure, # weeks