



PAIN MANAGEMENT INJECTION REQUEST FORM

Prior Auth Phone: 1-800-521-6622

Prior Auth Fax: 1-866-755-9949

Member Name: _____ ID#: _____ Date of Service _____

Physician: _____ Par/Non-Par _____ Provider ID # _____

Practice Name: _____

Facility name (for place of service) Par/Non -Par _____

Contact name: _____ Contact phone number: _____

Procedure CPT code(s) _____ Pain Related Diagnostic ICD code(s) _____

NOTE: One injection at a time will be authorized

INITIAL INJECTION REQUEST:

- Please document below Medical/Surgical/Pain History and Etiology (include any injection history and results from the injection)

- Please document below conservative medical treatments tried and failed up to this date to include prescription strength NSAIDS and a 4-6 week trial of professionally supervised physical therapy **within the past 6-9 months** or a statement to support failure of physical therapy or why therapy was not attempted (also include any Chiropractic treatment/Manipulation, use of TENS or bracing, etc., with dates of service)



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- Imaging Studies (MRI, CT scan , X-rays) list impression summary results related to pain complaint

SECOND INJECTION REQUEST:

- Please document below the percentage of pain relief, including duration of relief, from the initial injection

THIRD INJECTION REQUEST:

- Please document initiation of professionally supervised Physical Therapy started after the second injection, to include dates of service and outcomes. If PT was NOT initiated after second injection, please include statement below why it was not.

*All injections beyond the third injection will automatically require medical review *