Prior Authorization Form
Pain Management Injection Request

Phone: 1-800-521-6622 | Fax: 1-866-755-9949

Contact name:

Phone number: Fax number:

Member information:	
Member name:	Member ID number:
Date of birth:	Member's phone number:
Authorization number, if applicable:	
Primary insurance? ☐ Yes ☐ No	Name of carrier:
Primary insurer member ID:	Primary authorization number:

Provider information:	
Physician name:	Physician NPI:
Physician phone number:	Physician fax number:
Facility name:	Facility NPI:
Facility phone number:	Facility fax number:

Codes			
ICD diagnosis code	Description	CPT codes	Requested units per code

Pain management information request		
☐ Initial request ☐ Second request ☐ Third request **IF ANY CONSERVATIVE TREATMENT IS CONTRAINDICATED, PLEASE PROVIDE DETAIL IN CLINICAL NOTES.**		
Percent of relief:	Duration of relief:	Requested dates of service:
Conservative treatments? ☐ Tried and failed ☐ Contraindicated		
Opiates? ☐ Tried and failed ☐ Contraindicated		
Physical therapy? ☐ Tried and failed ☐ Contraindicated ☐ Other conservative treatment		
Is the pain: ☐ Unilateral ☐ Bilateral		
MRI? ☐ Yes ☐ No ☐ Nerve root compression		

CLINICAL NOTES TO SUPPORT THE MEDICAL NEED OF THIS SERVICE ARE REQUIRED.

ALL FIELDS MUST BE COMPLETED FOR REQUEST TO BE PROCESSED.