MedStar Family Choice

Fax completed form to MFC MD 1-888-243-1790 or 410-933-2274

INTERVENTIONAL PAIN MANAGEMENT PRIOR AUTHORIZATION FORM

Please attach copies of the patient's record.

****Please review our clinical criteria before submitting this form. ****

Patient Information

Patient Name:_____

MFC Member ID #: _____

Date of Birth: _____/_____/_____

Procedure Requested

Contact Person Name:_____

Contact Phone w/ext:_____ **Contact Fax:**_____

Date(s) of Service:_____

Facility name:_____

CPT Code(s) and Quantities Requested: _____

_____

ICD 10 Codes: _____

□ **Epidural Steroid Injection**:

Right side: vertebral location(s) requested_____

Left side: vertebral location(s) requested _____

□ **Facet Joint Injection**:

Right side: vertebral location(s) requested _____

Left side: vertebral location(s) requested_____

□ **Percutaneous Neuroablation**:

Right side: vertebral location(s) requested _____

Left side: vertebral location(s) requested_____

□ **Sacroiliac Joint Injection:**

Right or Left (circle one)

Diagnosis: □ cervical radiculopathy □ lumbar radiculopathy □ non-specific low back pain

□ cervical facet joint pain □ lumbar facet joint pain □ sacroiliac joint pain

□ other- specify:_____

Additional history:

Has the patient had a trial of **Activity Modification**? □ no □ yes - If yes, length of trial: _____weeks

Dates of Activity Modification: _____ to _____

Has the patient participated in **Physical Therapy**? □ no □ yes - If yes, length of therapy: _____weeks

Dates of Physical Therapy: _____ to _____

Physical Therapy location/office name:

_____

Please note: Physical Therapy notes must be submitted with this request

Injection history:

□ initial injection

□ repeat injection (please complete table below)

Date(s) of prior injection(s)	Type of Injection (epidural, facet, SI joint, ablation)	Vertebral location(s)	Side: Left, Right, or Bilateral	Percent pain relief	Duration of pain relief

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I certify that the information provided is accurate. Supporting documentation is available for audits.

Provider's signature _____

Provider's name _____

Provider NPI# _____

Date _____

Practice specialty: _____