Phone: 740-455-5199

Authorization Request: Facet Injections

Paravertebral Facet Joint or Medial Branch Block

Please Fax Request to: (740) 455-8817

Today's Date: _____

Member Information

Member Name: _____DOB: _____

Member ID#: _____ Employer: _____

Ordering Physician Information

Physician Name: _____Phone/Fax #: _____/_____

Physician Address: _____

Physician Tax ID/NPI: _____

Office Contact Person: _____

In Office Procedure? Yes _____ No _____ Date of Service: _____

Facility Information

Facility Name: _____ Facility Tax ID/NPI: _____

Facility Address: _____

Facility Phone/Fax: _____

Diagnosis: _____

Diagnosis Code(s): _____

Procedure Requested (CPT Code(s) w/ level(s) to be injected): _____

Initial Injection

Y☐ N☐ Pain for at least 3 months?

Y☐ N☐ Had a 2-week trial of NSAIDS (prescription strength, taken on regular basis **and** ordered by a physician unless contraindicated/intolerant *Please list start date, within 6 months _____

Y ☐ N ☐ Has had 4 weeks of activity modification

Y ☐ N ☐ Has attempted PT, Chiropractic care or home exercise program for 4 weeks within the past 12 months? *Please list start date: _____

Y ☐ N ☐ Associated neurological deficit?

Y ☐ N ☐ Contraindications such as severe spinal stenosis, disc herniation or radiculitis?

Diagnostic Phase Initial Injection

Y ☐ N ☐ Pain somatic, non-radicular neck, headache, upper extremity pain OR low back, lower extremity pain?

Y ☐ N ☐ History of spinal fusion at suspected level?

Diagnostic Phase Subsequent Injection

Y ☐ N ☐ Was there 50% reduction in pain & ability to perform prior painful movements for at least 1 week?

Therapeutic Phase Initial Injection

Y ☐ N ☐ Pain has returned?

Y ☐ N ☐ Facet Joint pain is known

Y ☐ N ☐ Prior injection provided 50% reduction in pain for 6 weeks?

Y ☐ N ☐ Member had improvement in physical and functional status

Therapeutic Subsequent Injection(s)

Date of previous injection: _____