QUALITY CARE PARTNERS
Phone: 740-455-5199

Authorization Request: Epidural Injections

Cervical & Thoracic – Intralaminar and Transforaminal

Lumbar – Intralaminar, Transforaminal, and Caudal

**Please Fax Request to: (740) 455-8817**

**Member Information**

Member Name: _____DOB: _____

Member ID#: _____ Employer: _____

**Ordering Physician Information**

Physician Name: _____Phone/Fax #: _____/_____

Physician Address: _____

Physician Tax ID/NPI: _____

Contact Person: _____

In Office? Yes _____ No _____

Facility Name: _____ Facility Tax ID/NPI: _____

Facility Address: _____

Diagnosis: _____

Diagnosis Code(s): _____

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

**Initial Injection**

Y N Does the member have recurrent/acute pain (cervical or thoracic or lumbar)?

Y N Documentation of nerve root compression?

Y N Has member had a 2-week trial of NSAIDS (prescription strength, taken on a regular basis **and** ordered by a physician – unless contraindication/intolerance)? *Please list start date, within 6 months: _____

Y N Has member had 4 weeks of activity modification?

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

Y N Are there radicular symptoms?

**Diagnostic Phase Initial Injection**

Y N Nerve root irritation such as radicular pain or sciatica?

Y N If radicular pain, has CT or MRI been completed within the past 12 months (unless contraindicated)? MRI Impression: _____

**Subsequent Injection(s)**

Date of previous injection(s): _____

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

**Therapeutic Phase Initial Injection**

Y N Pain has returned?

Y N Member has had a decline in functional status

Y N Member had a positive response to injections during diagnostic phase

**Subsequent Injection(s)**

Date of previous injection(s): _____

Y N Member had 50% reduction in pain for 6 weeks

Y N Improvement in physical and functional status