QUALITY CARE PARTNERS
Phone: 740-455-5199

Authorization Request: Radiofrequency Ablation
(Medial Branch Neurotomy, Radiofrequency Neurolysis, Facet Rhizotomy)

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 RFA Request

Y N Has the member had severe pain unresponsive to 6 months of conservative treatment?

Y N Has the member had prior spinal surgery? If yes, what level(s)? _____

Y N Negative imaging studies or failure to confirm disc herniation?

Y N Trial of injections consisting of one of the following:

__ 2 MBB (Cervical/Lumbar) and Lateral Branch Block for Sacral Area OR

__ 1 MBB and 1 Facet for Cervical and Lumbar

Y N Trial of injections has been successful in relieving the pain or marked decrease in intensity of pain?

Y N Has member had 50% reduction in pain with functional improvement for 10-12 weeks?

Repeat RFA

Circle any that apply:

Member has had: 1 MBB OR 1 Diagnostic Facet OR 1 SI Injection

Date for Previous RFA: _____