Phone: 740-455-5199

Authorization Request: Sacroiliac (SI) Injections

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): ___________________________________

Diagnostic Phase Initial Injection

Y N Pain present for at least 3 months?

Y N Has tried NSAIDS for 2 weeks (prescription strength, taken on a regular basis **and** ordered by a physician (unless contraindicated/intolerance)? *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 last 12 months? * Please list start date: ______________

Y N Somatic/nonradicular low back pain, lower extremity below L5

Diagnostic Phase Subsequent Injection

Date of previous injection(s): ________________________________

Y N Was there 50% pain relief w/ ability to perform prior painful movements without any significant pain for at least one week?

Y N Was the nerve anesthetized? If so, was there complete relief of pain?

Y N Was fluoroscopy used w/ previous injection?

Therapeutic Phase Initial Injection

Y N SI joint pain is known

Y N SI joint pain has returned

Y N Positive response with initial injections (50% reduction in pain for 6 weeks)

Y N Improvement in functional status

Therapeutic Phase Subsequent Injection(s)

Date of previous injection(s): ______________________