



Pain Management Prior Authorization Request Form

Instructions: 1. Use this form when requesting prior authorization of Pain Management services for members of EmblemHealth.
 2. Please complete and Fax this request form along with all supporting clinical documentation to OrthoNet at 1-844-296-4440.
 3. For assistance in completing this form, please call OrthoNet provider services toll free at 1-844-730-8503.

NOTE: The information transmitted is intended only for the person or entity to which it is addressed and may contain CONFIDENTIAL material. If you receive this material/information in error, please contact the sender and delete or destroy the material/information.

PROVIDER INFORMATION:

Fax Date: / /

Number of pages faxed : (including this cover page)

Facility or Provider Name

Street Address

City

State

ZIP

Telephone Number

 -

National Provider Identifier (NPI)

- Facility NPI Number
 Individual NPI Number

Fax Number

 -

Provider Tax ID Number

- Facility Tax ID Number
 Individual Tax ID Number

PATIENT INFORMATION:

First Name

Last Name

Date of Birth

 / /
 Month / Day / Year

Primary Diagnosis Code

1.

Health Plan Member ID Number

Please Select Spinal Region(s) which applies: Cervical Thoracic Lumbar Sacral

2. Requested Procedure(s): Epidural Steroid Injection Facet Joint Injection Facet Medial Branch Nerve Block: Local Steroid RFA
- Spinal Cord Stimulator: Trial Implant Pain Pump: Trial (Narcotic - Baclofen - Prialt) Implant (Narcotic - Baclofen - Prialt)

3. Please provide exact Epidural Levels or Facet Joint Levels or exact Medial Branch Nerves to be injected

Site of Injection: Left Right Bilateral

(Must be completed in order to process request)

4. Previous Epidural or Facet Injections(s)? Yes No

If yes, ___% Pain Relief lasted ___ weeks from last (Epidural or Facet injection) performed on Date: _____

CPT Code(s):

Anticipated Date of Service(s)

 / /
 Month / Day / Year

Requested Facility for Surgery/Procedure(s) (If Applicable)

City

State

Facility Tax ID Number



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