



Please return completed form to the Utilization Management Department at (401)459-6023.

Please refer to Neighborhood's *Clinical Medical Policy* which is available on our Neighborhood web site, www.nhpri.org for more detailed information about this benefit, authorization requirements, and coverage criteria.

MEMBER INFORMATION		
Member's Name:	Member's ID #:	Member's DOB:
PROVIDER INFORMATION		
Provider's Name:	Provider ID # (Please call Provider Services for your ID #):	Date of Request:
Date of Service:	Previous Auth #:	Place of Service (City/Town)/Facility:
Provider's Phone #:	Provider's Fax #:	Provider's Contact Name:
CLINICAL INFORMATION		
Diagnosis & Diagnosis Code:		Procedure & Procedure Code:
AUTHORIZATION FOR INJECTIONS:		
Anatomic location to be treated:		
Procedure requested:	<input type="checkbox"/> Epidural steroid injection – interlaminar or transforaminal <input type="checkbox"/> Spinal facet joint injection <input type="checkbox"/> Sacroiliac injection <input type="checkbox"/> Radiofrequency nerve ablation <input type="checkbox"/> Other _____ <input type="checkbox"/> Fluoroscopy	
Additional Required Information for Radiofrequency Ablation (rhizotomy):	Has a median nerve test with anesthetic (not steroid) been performed? Yes <input type="checkbox"/> No <input type="checkbox"/> Date spinal level was tested? _____ Efficacy and duration _____	
Type of Anesthetic:	Local anesthesia and conscious sedation by the physician performing the procedure are standard options for pain injections which do not require prior authorization. MAC anesthesia and/or anesthesia assistance is generally not medically necessary for epidural or facet joint injections. This requires prior authorization. Please indicate if this is the plan of care: <input type="checkbox"/> Monitored Anesthesia Care (MAC) <input type="checkbox"/> Anesthesia Assistance Required (i.e. anesthesiologist or nurse anesthetist in addition to physician performing procedure will be present during procedure) _____	



Member Name: _____

REQUIRED HISTORY & PHYSICAL INFORMATION FOR INJECTIONS
Please complete this section or submit office notes with the following information:

1.) History	a) Evidence of functional impairment in working, sleeping, performing ADLs _____ b) Current use of pain medication: dose, frequency, duration, efficacy. _____ c) Clinical exam: include provocative diagnostic tests _____
2) Previous treatments to same location:	Outcome & Duration of Improvement: _____ _____
3.) Recent Medical History:	
4) Musculoskeletal injections received in last 12 months:	
5) Physical therapy received in last 12 months	
6) Assessment and treatment of other contributors to chronic pain, if appropriate - please comment:	<input type="checkbox"/> Smoking: _____ <input type="checkbox"/> Overweight: _____ <input type="checkbox"/> Physical therapy and exercise: _____ <input type="checkbox"/> Counseling: _____

NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN

Signature of Treating Physician:	Date:
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NEIGHBORHOOD DECISION

Authorization #:	Dates of Service:	Services Approved:
UM Initials:	Notification Date:	<input type="checkbox"/> Not Approved - Letter to Follow