Neighborhood Health Plan OF RHODE ISLAND™

Non-Surgical Interventional Pain Management
Prior Authorization Form

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 NPI #:	Date Request Sent:
Date of Service:	Previous Auth #:	Place of Service (City/Town)/Facility:
Provider Contact and Phone #:	Provider's Fax #:	Ordering MD:

CLINICAL INFORMATION

CPT Codes	Units	Levels	Anatomic location to be treated:	Anesthesia
			❑ Bilateral or ❑ Unilateral ❑ Left or ❑ Right	❑ Local or ❑ MAC
			❑ Bilateral or ❑ Unilateral ❑ Left or ❑ Right	❑ Local or ❑ MAC
			❑ Bilateral or ❑ Unilateral ❑ Left or ❑ Right	❑ Local or ❑ MAC
Diagnosis:			Diagnosis Code:	

Procedure requested:	❑ Epidural steroid injection – ❑ Interlaminar or ❑ Transforaminal ❑ Spinal facet joint injection -- ❑ Diagnostic or ❑ Therapeutic ❑ Sacroiliac injection ❑ Radiofrequency nerve ablation ❑ Other ____ _____ _____ _____ ❑ Fluoroscopy

Please attach clinical notes that includes ALL of the following:

❑Last injection/Injection history ❑Relief from last injection ❑Provocative testing results
❑Previous physical therapy ❑Pain Medication used ❑Functional impairment
❑Comprehensive pain management treatment plan

NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN	
Signature of Treating Physician:	**Date:**

NEIGHBORHOOD DECISION
Authorization is not a guarantee of payment.

Authorization #:	Dates of Service:	Services Approved:
UM Initials:	**Notification Date:**	❑ **Not Approved - Letter to Follow**