Prior Authorization Form
Please Fax To (952) 853-8713 For Questions Call (888) 467-0774

Sacroiliac (SI) Injections to treat SI joint pain

Member information	
Member Name:	Member ID #:
DOB:	
Requester information	
Form Completed By:	Clinic/Facility:
Fax # for reply:	Phone #:
Billing Provider information	
Procedural Physician full name:	
NPI #:	Phone #
Fax #	
Billing Facility information	
Clinic/Facility Name:	Tax ID #:
Phone #:	Fax #:
Address:	
Procedure information: Prior authorization is required for each injection	
Proposed date of procedure / / or ☐ To Be Determined	
Primary Diagnosis: _____ ICD-9 or ICD-10 _____ Other diagnosis: _____ ICD-9 or ICD-10 _____ _____ ICD-9 or ICD-10 _____	
Procedure (CPT) Code:	
☐ Right Side ☐ Initial injection ☐ Repeat injection (fill out box below)	
☐ Left Side ☐ Initial injection ☐ Repeat injection (fill out box below)	
For repeats: A maximum of 3 injections in a 12 month period are allowed. Check and date injections already received. ☐1st injection date _____ ☐2nd injection date _____ ☐ 3rd injection date _____	
Please submit documentation that supports the medical necessity for this procedure.	

Please refer to the Sacroiliac joint pain treatment procedures policy, at https://etools.cooportunityhealth.com/coop-public/coverage-criteria/search.html for specific coverage criteria.

CoOportunity Health has contracted with HealthPartners Administrators, Inc. to provide claims processing, medical management and certain other administrative services.