Prior Authorization Form

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

Spinal Radiofrequency Ablation

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:	
Tax ID #:	Phone #
Fax #	
Billing Facility information	
Clinic/Facility Name:	Tax ID #:
Phone #	Fax #
Procedure information : Prior authorization is required for ablation procedure	
Proposed date of procedure / /	OR ☐ TBD
Primary Diagnosis: ______________________________	ICD9 : ____
Other diagnosis: ______________________________	ICD9: ____
______________________________	ICD9: ____
Procedure (CPT) Code:	
☐ Right Side List up to 3 **Vertebral** Level(s) to be treated	
☐ Left Side List up to 3 **Vertebral** Level(s) to be treated	

REPEAT RFA PROCEDURES: A maximum of one RFA treatment procedure per level per side in a 6 month period is allowed. Please identify the date and level(s) previously treated.

Level(s)________________________________ Date___________________

Level(s)________________________________ Date ___________________

Level(s)________________________________ Date ___________________

Include documentation of one trial diagnostic medial branch block (MBB) injection and the pre/post-injection pain scores.

Please submit documentation that supports the medical necessity for this procedure.

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