Prior Authorization Form
Please Fax To (952) 853-8712 For Questions Call (888) 467-0774
Epidural Steroid Injection Therapy for Low Back Pain

Member information	
Member Name:	Member ID #:
DOB:	
Requester information	
Form Completed By:	Clinic/Facility:
Fax # for reply:	Phone #:
Provider information	
Procedural Physician full name:	
NPI	Phone #
Fax #	
Billing Facility information	
Clinic/Facility Name:	Tax ID #:
Phone #	Fax #
Procedure information: Prior authorization is required for each injection	
Proposed date of procedure / / or ☐ To Be Determined	
Primary Diagnosis	ICD9 or ICD10
Secondary Diagnosis	ICD9 or ICD10
Procedure (CPT) Code(s):	
List spinal Lumbar level(s) for injection:	
☐ Right side ☐ Initial injection ☐ Repeat injection (fill out box below)	
☐ Left side ☐ Initial injection ☐ Repeat injection (fill out box below)	
For Repeats: List all previous epidural injections done in the past 12 months Date:_____ Side and level(s)done_____ Date:_____ Side and level(s)done_____ Date:_____ Side and level(s)done_____ Date:_____ Side and level(s)done_____ Date:_____ Side and level(s)done_____	

Please include documentation of the following

- Evidence of radicular pain on physical exam and /or imaging.
- Evidence that a tumor or other mass was ruled out as a cause of the pain.
- Documentation of physical therapy with in the last 6 months.
- If repeat, documentation of pain relief by a pre and post Visual Analog Scale