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P.O. Box 1309
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# MULTIDISCIPLINARY INTENSIVE DAY TREATMENT PROGRAM FOR CHRONIC PAIN
## Prior Approval Request Form

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| **Behavioral Health Department** | **Phone number: 1-866-669-3856** |
| **Coverage Policy**: ***Chronic Pain Programs – Behavioral Health, Multidisciplinary Day Treatment*** | |

**Definition:** A multi-disciplinary intensive day treatment program for chronic pain will consist at a minimum of a physician with training and expertise in pain management, a behavioral health specialist, and a spine physical therapist.

**Please answer ALL of the following questions.**
**This information is REQUIRED to determine medical criteria are met prior to program participation.**

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| **Member Name:** | **Member ID number**: | **DOB**: |
| **Patient's Primary Care Physician Treating the Member's Pain:** | | **Clinic Phone #:** |
| | | **Fax #:** |
| **Physician Requesting Authorization for Chronic Pain Program:** | | **Clinic Phone #:** |
| | | **Fax #:** |
| **Name of Specific Pain Program Requested:** | | **Clinic Phone** #: |

**Please answer all of the following questions. This information is required to determine eligibility for program participation:**

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| 1. What is the date of onset causing the chronic pain syndrome? | |
| 2. What is the primary diagnosis causing the chronic pain syndrome? (with code) | |
| 3. Date of onset of Primary diagnosis | |
| 4. How long have you been caring for this patient? | |
| 5. Has this patient participated in an active Physical Therapy regimen in the past year? | * No<br>* Yes - Where: |
| 6. Has the patient failed an active physical therapy program? | * No<br>* Yes - Explain: |

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

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| 7. Has the patient had course of treatment with a licensed mental health therapist that specializes in Chronic Pain in the past year? | * No<br>* Yes – Name of Provider: |
| 8. Has the patient failed a course of mental health therapy with a licensed mental health therapist that specializes in Chronic Pain? | * No<br>* Yes - Explain: |
| 9. Please describe your current Care Plan for your patient. | |
| 10. Please list the patient's current medications. | 1. _____<br>2. _____<br>3. _____<br>4. _____<br>5. _____ |
| 11. Has your patient been evaluated in the past year by a physician who specializes in Chronic Pain? | * No<br>* Yes – Name of Provider: |
| 12. Please list what medical interventions have happened to this patient | |
| 13. Outcomes you expect from the patient participating in this program | |
| 14. Will you be the physician collaborating with the pain program to support the treatment plan and seeing this patient after completion of the program? | * Yes<br>* No – Indicate who will be following: |
| **PRINT name of Requesting Provider:_____**<br><br>**Signature of Requesting Provider:** **DATE:** | |
| **Fax completed form back to coOportunityHealth: (952) 853-8830** | |

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| **To be completed by Behavioral Health only:**<br>Patient agrees to case management services. _____Yes _____No |