Chesapeake Employers Insurance

PRECERTIFICATION FORM (Injections)

(Fax to 410-494-2079)

(If not previously submitted, please include supporting documentation.)

PATIENT INFORMATION

Last Name:	**First Name:**	
Claim #:	**DOB:**	**Injury Date:**

PERSON SUBMITTING REQUEST

Last Name:	**First Name:**	**Date:**
Phone:	**Fax:**	**Email:**

PROVIDER

Last Name:	**First Name:**	
Phone:	**Fax:**	**Email:**
Tax ID:	**Vendor #:**	**Service Date(s):**

FACILITY

Name:		**Phone:**
Fax:	**Tax ID:**	**Vendor #:**

INJECTIONS

TYPE	LEVEL(s)	LOCATION
☐ Intralaminar Epidural Steroid Injection		☐ Right ☐ Left ☐ Bilateral
☐ Transforaminal Epidural Steroid Injection		☐ Right ☐ Left ☐ Bilateral
☐ Caudal Epidural Steroid Injection		☐ Right ☐ Left ☐ Bilateral
☐ Selective Nerve Root Block		☐ Right ☐ Left ☐ Bilateral
☐ Facet Joint Intra-Articular Block		☐ Right ☐ Left ☐ Bilateral
☐ Radiofrequency Medial Branch Neurotomy		☐ Right ☐ Left ☐ Bilateral
☐ SI Joint Injection		☐ Right ☐ Left ☐ Bilateral
☐ Service Not Listed:		

INJECTION LOCATION(s):

DATE OF PRIOR INJECTION	TYPE OF INJECTION	LEVEL(s)

COMPLETE MINI-ASSESSMENT FOR SUBSEQUENT INJECTIONS

Pain level: ☐ Increased ☐ Decreased ☐ Same	**Percentage:**	**Improved overall function? ☐ Yes ☐ No ☐ Same**
Change in medications? If yes, explain:		

SERVICE CODES

ICD-10(s:)	**CPT(s):**
Additional code(s):	

ADDITIONAL INFORMATION

Chesapeake Employers' Insurance Company
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