



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

Table with columns: TYPE, LEVEL(s), LOCATION. Rows include Intralaminar Epidural Steroid Injection, Transforaminal Epidural Steroid Injection, Caudal Epidural Steroid Injection, Selective Nerve Root Block, Facet Joint Intra-Articular Block, Radiofrequency Medial Branch Neurotomy, SI Joint Injection, Service Not Listed.

INJECTION LOCATION(s):

Table with columns: 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

Empty box for additional information