Epidural Steroid Injection(s): Prior Authorization Request Form

Please download and complete form in Adobe or Fax. Do not complete in browser.

Please Note: For non-urgent pain management injection requests, complete this form and submit with all appropriate and relevant medical records (imaging, office visit notes, attempted conservative treatments, etc.). Failure to submit appropriate relevant medical records may result in determination delays and denials.

BlueCross BlueShield of Tennessee: Commercial Members Only

Use for CPT® codes 0228T, 0229T, 0230T, 0231T, 62320, 62321*, 62322*, 62323*, 62324, 62325, 62326, 62327, 64479, 64480**, 64483, 64484

* *Codes 62321, 62322, & 62323 are unilateral and do not require a modifier*

** *Code 64480 uses LT, and/or RT modifier only, not 50 (bilateral)*

Requested CPT® Code	Quantity	Modifier: LT, RT or 50 (bilateral)
Primary Diagnosis Code	Anticipated Date of Service (mm/dd/yyyy)	

Patient/Member Information			
First Name	Last Name	DOB (mm/dd/yyyy)	
Health Plan	Member ID	Member ID Suffix:	

Provider Information		
Contact First Name:	Last Name:	
Contact Phone:	Contact Fax:	
Treating Provider's First Name:	Treating Provider's Last Name:	
TIN:	NPI:	
BCBSTN Provider ID #:		
Practice/Group Name:		
Address:		Suite #:
City:	State:	Zip:
Notification Method Preference: ☐ Postal Mail	☐ Fax	☐ Portal

Facility/Place of Service			
Is Facility Setting same as practice? ☐ Yes ☐ No ***If yes, do not complete facility information below.**			
Facility Setting: ☐ In-Office ☐ Outpatient ☐ Observation ☐ Inpatient Hospital			
Facility Name:			
TIN:	NPI:		
BCBSTN Provider ID #:			
Address:		Suite #:	
City:	State:	Zip:	
Contact First Name:	Last Name:		
Contact Phone:	Contact Fax:		
Notification Method Preference: ☐ Postal Mail ☐ Fax ☐ Portal			

Patient Clinical Information

I. What is the reason for epidural steroid injection (ESI)? [Select all that apply]

- ☐ Chronic or acute cervical pain
- ☐ Chronic or acute thoracic pain
- ☐ Chronic or acute lumbar pain
- ☐ Other

II. Is there documentation of confirmed radiculopathy by any of the following? [Select all that apply]

- ☐ Physical exam findings
- ☐ Imaging
- ☐ Neuro-testing
- ☐ No confirmed radiculopathy

III. What conservative treatment has been attempted? [select all that apply]

- ☐ Medication – NSAIDs
- ☐ Medication – analgesics
- ☐ Medication – other (steroids, muscle relaxants, nerve pain medication, etc.)
- ☐ Rest or activity modification
- ☐ Physical Therapy
- ☐ None of the above

IV. How long have conservative treatments been attempted? [select one]

- ☐ Less than four (4) weeks
- ☐ Four (4) weeks or longer

V. Is the procedure planned to be performed with fluoroscopic guidance? [select one]

- ☐ Yes
- ☐ No

VI. Has a previous injection been performed? If so, how many? [select one]

- ☐ No previous injection – first treatment
- ☐ One (1) previous ESI injection
- ☐ Two (2) previous ESI injections
- ☐ Three (3) or more previous ESI injections

List All Dates of Previous Injections: _____

VII. Are any of the following present? [select all that apply]

- ☐ Known allergy to injectate
- ☐ Insufficient epidural space due to prior surgery, compression, or congenital condition
- ☐ Bleeding disorder or anticoagulant use
- ☐ Infection (either systemic or at the injection site)
- ☐ Uncontrolled hypertension
- ☐ Diabetes
- ☐ Congestive heart failure
- ☐ More than two (2) previous ESI injections without relief of pain within 2 to 6 weeks
- ☐ None of the above

ADDITIONAL COMMENTS:

To submit the following form electronically, please select the submit button:

To clear all the above fields in the form, please select clear button:

To print the above form, select the print button:

To submit this request via fax, you may submit this form to TurningPoint Healthcare Solutions at (423) 800-5302