PAIN MANAGEMENT
EPIDURAL STEROID INJECTION
AUTHORIZATION REQUEST FORM

Utilization Management local phone: 866-747-0586
Utilization Management fax: 423-800-5302

Please Note: For non-urgent pain management injection requests, please complete the 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.

*Requests can be submitted online at any time through Availity.com.
*Contact the eBusiness Marketing team for all your Availity® registration and training needs by calling 423-535-5717 option 2 or emailing eBusiness_marketing@bcbst.com.

BlueCross BlueShield of Tennessee: Commercial Members Only

Use for CPT codes 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)***

Today's date (mm/dd/yyyy): __ / __ / ____

MEMBER INFORMATION		
Member name:		**Date of birth (mm/dd/yyyy): __ / __ / ____**
Member ID:	**Suffix:**	**Health plan:**

RENDERING PROVIDER INFORMATION	
Contact name:	
Contact phone:	**Contact fax:**
Provider name:	
Provider NPI:	**Provider Mailing address or fax number:**
Provider TIN:	
BCBSTN Provider ID:	
Practice/group name:	
Notes:	**Provider physical address:**
	Notification method preference: ○ Postal mail ○ Fax

*Requests can be submitted online at any time through Availity.com
*Contact the eBusiness Marketing team for all your Availity® registration and training needs by calling 423-535-5717 option 2 or emailing eBusiness_marketing@bcbst.com.

PAIN MANAGEMENT
EPIDURAL STEROID INJECTION
AUTHORIZATION REQUEST FORM
Utilization Management local phone: 866-747-0586
Utilization Management fax: 423-800-5302

Where will the procedure take place?			
◯ Provider office	◯ Outpatient	◯ Observation	◯ Inpatient hospital
Facility name:		**BCBSTN Provider ID:**	
Facility TIN:		**Facility contact name:**	
Facility NPI:		**Facility contact phone:**	
Facility physical address:		**Facility contact fax:**	

Requested procedure code	**Modifier: LT, RT or 50 (bilateral)**	**Quantity**	**Spine level**
Primary Diagnosis code:		**Anticipated date of service (mm/dd/yyyy): __ / __ / ____**	
Additional Diagnosis code(s):			
Patient's height:	**Patient's weight:**	**Patient's BMI:**	

What is the reason for epidural steroid injection (ESI)? Select all that apply.	**What conservative treatment has been attempted? Select all that apply.**
☐ Chronic or acute cervical pain ☐ Chronic or acute thoracic pain ☐ Chronic or acute lumbar pain ☐ Other	☐ Medication – NSAIDs ☐ Medication – analgesics ☐ Medication – other (steroids, muscle relaxants, nerve pain medication, etc) ☐ Rest or activity modification ☐ Physical Therapy ☐ None of the above

*Requests can be submitted online at any time through Availity.com
*Contact the eBusiness Marketing team for all your Availity® registration and training needs by calling 423-535-5717 option 2 or emailing eBusiness_marketing@bcbst.com.

Is there documentation of confirmed radiculopathy by any of the following? Select all that apply. ☐ Physical exam findings ☐ Imaging ☐ Neuro-testing ☐ No confirmed radiculopathy	**How long have conservative treatments been attempted? Select one.** ◯ Less than four (4) weeks ◯ Four (4) weeks or longer
Is the procedure planned to be performed with fluoroscopic guidance? Select one. ◯ Yes ◯ No **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:**	**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

By submitting this request, you are confirming that you have provided all clinical information available pertinent to this request and you are requesting the decision be made based on information provided in your submission.	
Form completed by:	**Date:**

*Requests can be submitted online at any time through Availity.com
*Contact the eBusiness Marketing team for all your Availity® registration and training needs by calling 423-535-5717 option 2 or emailing eBusiness_marketing@bcbst.com.