PAIN MANAGEMENT NEUROTOMY 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 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 64633, 64634*, 64635, 64636*

**** Codes 64634 and 64636 use LT, and/or RT modifiers 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

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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 type of intervention is planned? Select applicable.	**How much pain relief was received from diagnostic nerve block? Select one.**
☐ Non-pulsed radiofrequency denervation ☐ Pulsed radiofrequency denervation ☐ Laser denervation ☐ Chemical denervation (via alcohol, phenol, or high-concentration local anesthetic) ☐ Cryo-denervation ☐ Low grade thermal energy (<80 degrees Celsius)	○ No diagnostic nerve block completed ○ 0-19% pain relief ○ 20-39% pain relief ○ 40-59% pain relief ○ 60-79% pain relief ○ 80-100% pain relief

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Is this being performed to treat medial branches of the dorsal spinal nerves? Select one. ◯ Yes ◯ No	**How long has it been since the diagnostic injection was completed? Select one.** ◯ Less than 1 week (0-6 days) ◯ 1 week (7-13 days) ◯ 2 weeks (14-20 days) ◯ 3 or more weeks (21+ days)
Has a previous radiofrequency neurotomy been performed at this joint within 6 months? Select one. ◯ Yes How many neurotomy procedures has the patient had at this joint in the past 6 months? ____ What was the result of the initial procedure(s)? Reduction in pain by _____ % for a duration of _____ months. ◯ No previous radiofrequency neurotomy – first treatment at this joint	**Have there been more than two (2) thermal radiofrequency sessions during the calendar year in the spinal region (cervical/thoracic, lumbar or sacroiliac) intended to be treated?** ◯ Yes ◯ No Dates and Levels of All Previous Radiofrequency Sessions:
Which region of the spine will be treated? Select applicable. ☐ Cervical/Thoracic ☐ Lumbar ☐ Sacroiliac	

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:**

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