# Neurotomy: 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, 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.

## BlueCross BlueShield of Tennessee: Commercial Members Only

## Use for CPT codes 64633, 64634, 64635, 64636

| Requested CPT Code | Quantity | Modifier: LT, RT, or 50 (bilateral) |
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|---|---|
| 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 |

| Requesting Provider | | |
|---|---|---|
| Contact First Name: | Last Name: | |
| Contact Phone: | Contact Fax: | |
| Providers First Name: | Providers Last Name: | |
| TIN: | NPI: | |
| BCBSTN Provider ID #: | | |
| 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 Facility 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 type of intervention is planned? [select applicable]<br>☐ Non-pulsed radiofrequency denervation<br>☐ Pulsed radiofrequency denervation<br>☐ Laser denervation<br>☐ Chemical denervation (via alcohol, phenol, or high-concentration local anesthetic)<br>☐ Cryo-denervation<br>☐ Low grade thermal energy (<80 degrees Celsius) |
| II. | Is this being performed to treat medial branches of the dorsal spinal nerves?<br>☐ Yes<br>☐ No |
| III. | How much pain relief was received from diagnostic nerve block?<br>☐ No diagnostic nerve block completed<br>☐ 0-19% pain relief<br>☐ 20-39% pain relief<br>☐ 40-59% pain relief<br>☐ 60-79% pain relief<br>☐ 80-100% pain relief |
| IV. | How long has it been since the diagnostic injection was completed?<br>☐ Less than 1 week (0-6 days)<br>☐ 1 week (7-13 days)<br>☐ 2 weeks (14-20 days)<br>☐ 3 or more weeks (21+ days) |

| | |
|---|---|
| V. | Has a previous radiofrequency neurotomy been performed at this joint within 6 months?<br>☐ Yes<br>How many neurotomy procedures has the patient had at this joint in the past 6 months? ____<br>What was the result of the initial procedure(s)?<br>Reduction in pain by _____ % for a duration of _____ months.<br>☐ No previous radiofrequency neurotomy – first treatment at this joint |
| VI. | Which region of the spine will be treated?<br>☐ Cervical/Thoracic ☐ Lumbar ☐ Sacroiliac |
| VII. | 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?<br>☐ Yes<br>☐ No<br>Dates and Levels of All Previous Radiofrequency Sessions: _____ |

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| A**DDITIONAL 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 with your, select the print button:

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