GEHA
The Benefits of Better Health

Pain Management Authorization
(epidurals, facets, ablations, spinal stimulators, pain pumps)

Date of request: _____ Anticipated service date: _____

Patient name: _____ Phone: _____

ID number: _____ Date of birth: _____

Member address: _____

_____

Provider name: _____ Tax ID: _____

Address: _____

_____

Contact: _____

Phone: _____ Ext: _____ Fax: _____

The clinical information below is mandatory to evaluate medical necessity and should be completed by physician or other clinical staff.

Place of service: ☐ Hospital inpatient ☐ Hospital outpatient ☐ Surgery center ☐ Office

Is this procedure diagnostic? ☐ Yes ☐ No Is this procedure therapeutic? ☐ Yes ☐ No

Applicable area: ☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Sacral

What levels? _____

Is this a pre-service or post-service request? ☐ Pre-service ☐ Post-service

Primary diagnosis: _____ ICD-10 codes: _____

List all proposed CPT/HCPCS procedure codes – including any anesthesia or sedation* required for pain management procedures: _____

**Note: Any anesthesia or sedation submitted within a claim for pain management services but not prior authorized will be subject to review for medical necessity upon GEHA's receipt of the claim.*

Date last procedure was performed: _____

Was type of procedure was it? ☐ Epidural ☐ Facet ☐ Radio frequency

What percentage pain relief and for how long? _____

What conservative treatments have been tried for the chief complaint/primary diagnosis being treated?

_____

_____

IMPORTANT: In addition to this form, submit (1) a complete history and physical, (2) an applicable current/complete clinical note that is legible, (3) a procedure report [if this is a post-procedure request] and (4) all pertinent test results.
Fax completed form and supporting documents to OrthoNet at 888.539.3049.

Questions: Call OrthoNet at 877.304.4399.

Payable benefits are subject to the terms and conditions of the Health Benefit Plan.