Pain Management Authorization Form

Refer to the back of the patient's ID card under the heading Prior Authorization for the appropriate contact information.

Purpose of this form

You can use this form to initiate your precertification request. The form will also help you know what supporting documentation is needed for GEHA to review your request.

You can find our coverage policies at **Provider resources**. These will allow you to see the criteria used to determine medical necessity and procedures that are not allowable.

For us to review your request properly and to avoid delay, you must complete all sections of the form and provide the necessary supporting documentation. If you have questions about the form or need help, you can speak with a surgical specialist at 800.821.6136, ext. 3100.

After you have completed the form

Preauthorization reviews are completed within 15 days from the time that we receive complete information. Please allow for this time when scheduling the procedure. We are not able to consider a request "urgent" unless waiting the regular time limit for authorization could seriously jeopardize a patient's life, health or ability to regain maximum function. Post-service reviews are completed within 30 days.

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Pain Management Authorization Form

(epidurals, facets, ablations, spinal stimulators, pain pumps)

Refer to the back of the patient's ID card under the heading Prior Authorization for the appropriate contact information.

Date of request: _____

Anticipated service date (allow up to 15 days for a determination): _____

Patient name: _____ Phone: _____

Preferred pronouns: _____ (optional)

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 to avoid any delays.

Primary diagnosis: _____ ICD-10 codes: _____

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

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

Type of request: ☐ Pre-service ☐ Post-service

Was type of procedure was it: ☐ Epidural ☐ Facet ☐ Radio frequency
☐ Spinal Stimulator ☐ Pain Pump

Is this procedure: ☐ Diagnostic ☐ Therapeutic (Date of last/type of procedure: _____)

What percentage pain relief and for how long: _____

Applicable area: ☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Sacral

Specify **levels**: _____

Indicate: ☐ Unilateral and which side: _____ ☐ Bilateral

Indicate: ☐ Radicular Pain ☐ Non-Radicular Pain

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Date of last imaging related to this procedure: _____

Please list conservative treatments with date(s) that have been tried for the chief complaint/primary diagnosis being treated along with pain scale: _____

_____

**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.*

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 GEHA at 816.257.3515 or 816.257.3255, or email caremanagementsurgery@geha.com.

Important information regarding our Turn Around Time

Our reviews are completed within **15 days** from the time that we receive complete information. Please allow for this time when scheduling the procedure. We are not able to consider a request "urgent" unless waiting the regular time limit for authorization could seriously jeopardize a patient's life, health or ability to regain maximum function.

Questions: Call GEHA at 800.821.6136, ext. 3100.
Payable benefits are subject to the terms and conditions of the Health Benefit Plan.