Musculoskeletal Program:
Interventional Pain Intake Form

Provider portal available for seamless submission of cases

www.evicore.com

Please use this fax form for NON-URGENT requests only. Failure to provide all relevant information may delay the determination. Phone and fax numbers may be found on eviCore.com under the Guidelines and Forms section. You may also log into the provider portal located on the site to submit an authorization request.

URGENT (same day) REQUESTS MUST BE SUBMITTED BY PHONE

PATIENT

First Name:		MI:		Last Name:	
Email Address:					
Member ID:		DOB (mm/dd/yyyy):		Gender: ☐ Male	☐ Female
Street Address:				Apt #:	
City:		State:		Zip:	
Home Phone:		Cell Phone:		Primary: ☐ Home	☐ Cell
Member Health Plan/Insurer:					

PROVIDER

First Name:		Last Name:			
Primary Specialty:		TIN:		NPI:	
Physician Phone:		Physician Fax:			
Address:				Suite #:	
City:		State:		Zip:	
Office Contact:		Ext:		Email:	

ADMINISTRATIVE

Diagnoses:

Requested Procedure:

CPT Code	*Quantity*	*Modifier: LT, RT, or 50 (bilateral)*

** Requests for injectates other than steroid, local anesthetic, or contrast will be directed to the health plan for management.*

Anticipated Date of Service:			
Place of Service:	☐ Office-11	☐ Outpatient Hospital-22	☐ Ambulatory Surgery Center (ASC)-24
	☐ Other:		
Has / have conservative treatments been attempted:	☐ Yes Type: Duration:	☐ No	
Has / have previous injection(s) been performed?	☐ No, first treatment	☐ Yes, _____ (qty) previous injection(s)	
Date(s) of previous injection(s):			
Response from previous injection(s):	☐ Yes, _____% improvement ☐ Yes, improvement in ADL / function ☐ No improvement		

Medical records, including an exam narrative, office notes, results of diagnostic tests, and any equivalent notes must be submitted with this form.

Please note this document is to be used as a tool to assist with prior authorization requests. Providing all of the information listed on this tool in no way grants approval of the requested procedure(s). All requests are subject to a review for Medical Necessity, at which time a determination is made. Submission of this form, without medical records, will limit our ability to administer a determination.

Member Name:		Member ID:		Provider Name:	