



Please Note: For non-urgent pain management injection requests, please complete the 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](https://www.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 62320, 62321*, 62322*, 62323*, 62324, 62325, 62326, 62327, 64479, 64480**, 64483, 64484

**Codes 62321, 62322, & 62323 are unilateral and do not require a modifier*

***Code 64480 uses LT, and/or RT modifier 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: <input type="radio"/> Postal mail <input type="radio"/> Fax

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**PAIN MANAGEMENT
EPIDURAL STEROID INJECTION
AUTHORIZATION REQUEST FORM**
Utilization Management local phone: 866-747-0586
Utilization Management fax: 423-800-5302

Where will the procedure take place? <input type="radio"/> Provider office <input type="radio"/> Outpatient <input type="radio"/> Observation <input type="radio"/> 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 is the reason for epidural steroid injection (ESI)? Select all that apply. <ul style="list-style-type: none"> <input type="radio"/> Chronic or acute cervical pain <input type="radio"/> Chronic or acute thoracic pain <input type="radio"/> Chronic or acute lumbar pain <input type="radio"/> Other 	What conservative treatment has been attempted? Select all that apply. <ul style="list-style-type: none"> <input type="radio"/> Medication – NSAIDs <input type="radio"/> Medication – analgesics <input type="radio"/> Medication – other (steroids, muscle relaxants, nerve pain medication, etc) <input type="radio"/> Rest or activity modification <input type="radio"/> Physical Therapy <input type="radio"/> None of the above
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<p>Is there documentation of confirmed radiculopathy by any of the following? Select all that apply.</p> <ul style="list-style-type: none"> <input type="radio"/> Physical exam findings <input type="radio"/> Imaging <input type="radio"/> Neuro-testing <input type="radio"/> No confirmed radiculopathy 	<p>How long have conservative treatments been attempted? Select one.</p> <ul style="list-style-type: none"> <input type="radio"/> Less than four (4) weeks <input type="radio"/> Four (4) weeks or longer
<p>Is the procedure planned to be performed with fluoroscopic guidance? Select one.</p> <ul style="list-style-type: none"> <input type="radio"/> Yes <input type="radio"/> No 	<p>Are any of the following present? Select all that apply.</p> <ul style="list-style-type: none"> <input type="radio"/> Known allergy to injectate <input type="radio"/> Insufficient epidural space due to prior surgery, compression, or congenital condition <input type="radio"/> Bleeding disorder or anticoagulant use <input type="radio"/> Infection (either systemic or at the injection site) <input type="radio"/> Uncontrolled hypertension <input type="radio"/> Diabetes <input type="radio"/> Congestive heart failure <input type="radio"/> More than two (2) previous ESI injections without relief of pain within 2 to 6 weeks <input type="radio"/> None of the above
<p>Has a previous injection been performed? If so, how many? Select one.</p> <ul style="list-style-type: none"> <input type="radio"/> No previous injection – first treatment <input type="radio"/> One (1) previous ESI injection <input type="radio"/> Two (2) previous ESI injections <input type="radio"/> Three (3) or more previous ESI injections <hr/> <p>List All Dates of Previous Injections:</p>	

<p>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.</p>	
<p>Form completed by:</p>	<p>Date:</p>

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