Phone: 740-455-5199

Authorization Request: Sacroiliac (SI) Injections

Please Fax Request to: (740) 455-8817

Today's Date: _____

Member Information

Member Name: _____DOB: _____

Member ID#: _____ Employer: _____

Ordering Physician Information

Physician Name: _____Phone/Fax #: _____/_____

Physician Address: _____

Physician Tax ID/NPI: _____

Contact Person: _____

In Office? Yes _____ No _____ Date of Service: _____

Facility Information

Facility Name: _____

Facility Address: _____

Facility Tax ID/NPI: _____ Facility Phone/Fax: _____

Diagnosis: _____

Diagnosis Code(s): _____

Procedure Requested (CPT Code(s) w/ level(s) to be injected): _____

Diagnostic Phase Initial Injection

Y ☐ N ☐ Pain present for at least 3 months?

Y ☐ N ☐ Has tried NSAIDS for 2 weeks (prescription strength, taken on a regular basis **and** ordered by a physician (unless contraindicated/intolerance)? *Please list start date, within 6 months: _____

Y ☐ N ☐ Has had 4 weeks of activity modification?

Y ☐ N ☐ Has attempted PT, chiropractic care or home exercise program for 4 weeks within the last 12 months? * Please list start date: _____

Y ☐ N ☐ Somatic/nonradicular low back pain, lower extremity below L5

Diagnostic Phase Subsequent Injection

Date of previous injection(s): _____

Y ☐ N ☐ Was there 50% pain relief w/ ability to perform prior painful movements without any significant pain for at least one week?

Y ☐ N ☐ Was the nerve anesthetized? If so, was there complete relief of pain?

Y ☐ N ☐ Was fluoroscopy used w/ previous injection?

Therapeutic Phase Initial Injection

Y ☐ N ☐ SI joint pain is known

Y ☐ N ☐ SI joint pain has returned

Y ☐ N ☐ Positive response with initial injections (50% reduction in pain for 6 weeks)

Y ☐ N ☐ Improvement in functional status

Therapeutic Phase Subsequent Injection(s)

Date of previous injection(s): _____