PASSPORT ADVANTAGE (HMO SNP)

Pain Management Prior Authorization Request Form

Complete this entire treatment plan to avoid delays in processing your request
Fax completed request to: **888-367-7480**

☐ Routine Request ☐ Urgent Request

URGENT / EXPEDITED is defined as: if waiting under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. For Urgent / Expedited requests you may call: **844-865-7864**

Today's date _____ Member Name _____ Member ID _____

Procedure(s) requested with CPT code(s) _____

Number _____ Frequency _____ Requested start date _____

Diagnosis _____ Height _____ Weight _____

HISTORY: include onset of symptoms, etiology of pain, specific patient complaints, and pertinent surgical history:

Date of onset of symptoms _____ Accident or work-related? ☐ YES ☐ NO

If yes, provide TPL (Third Party) information _____

PHYSICAL EXAM FINDINGS: include objective functional assessment, neurological deficits noted, degree of disability, responses to previous treatment, and progression of condition

RADIOLOGIC STUDIES: include dates and results

FUNCTIONAL/PHYSICAL DISABILITY: include extent of change using scale provided

Symptoms: 0 = no pain to10 = extreme pain

☐ Pain – location _____

☐ Headache – describe _____

☐ Other – specify _____

Level of impairment: 0 = no impairment to 3 = severe impairment

☐ Driving _____ ☐ Personal Care _____

☐ Sleep _____ ☐ Working _____

☐ Recreation _____ ☐ Difficulty Lifting _____

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CURRENT MEDICATIONS FOR ABOVE DIAGNOSIS:

NSAID's

Name of Drug	Dosage	Date Started
_____	_____	_____
_____	_____	_____
_____	_____	_____

Opiates

Name of Drug	Dosage	Date Started
_____	_____	_____
_____	_____	_____
_____	_____	_____

PREVIOUS INTERVENTIONS:

Physical Therapy:
How many visits _____ When _____ Where _____
Relief? ☐ YES ☐ NO

Chiropractic:
How many visits _____ When _____ Where _____
Relief? ☐ YES ☐ NO

Injections:
1. Area treated _____ How many injections _____ When _____ Where _____

2. Area treated _____ How many injections _____ When _____ Where _____

3. Area treated _____ How many injections _____ When _____ Where _____

PROVIDER INFORMATION:

Requesting Provider Name: _____ ID Number _____

Facility: _____ ID Number _____

Contact Name: _____Telephone: _____ Fax: _____