Horizon
Horizon NJ Health

Date of Request: _____

In place of this form you can submit Authorization Requests online securely via NaviNet. If you are not registered, please visit NaviNet.net and click *Sign Up* or call NaviNet Customer Care at 1-888-482-8057.

Pain Management Authorization Form

Requirements: *Clinical information, including previous conservative treatment and diagnostic test results are to be included in office visit notes to support requests for approval of: 1st injection; or a change in previous pain management code; or a request for more than 3 injections.* ***Notification is required for any date of service change.***

Fax completed form to: Horizon NJ Health **1-609-583-3014**

General Information

Member Name: _____ Member ID #: _____ DOB: _____

Provider Contact Name: _____ Phone #: _____ Fax #: _____

List Any Additional Insurance: _____

Policy Name/Number: _____

Medical Information Needed

Date/Date Range of Service: _____

Days/Units Requested: _____

Primary Diagnosis: _____ Other Chronic Diagnosis: _____

ICD-10 Codes: _____

ICD-10 Codes: _____

Procedure(s) Requested: _____

CPT Codes Requested: _____

Requesting Provider _____ **ID # & NPI #:** _____ **TIN #:** _____

Servicing Facility: _____ **ID # & NPI #:** _____ **TIN #:** _____

Location of Service: ☐ **MD Office** ☐ **Outpatient Hospital** ☐ **Hospital SPU/OR** ☐ **Other**

Additional Required Information

Initial injections: ☐ Yes ☐ No Date of last injection: _____ % of relief/VAS: _____

Level of injection: _____ **Or muscle group (Trigger Point):** _____

Subsequent injection **2nd** **3rd** **Dates of injections:** _____ **% of relief/VAS:** _____

Signs/Symptoms: _____ **Date of onset:** _____

Physical Therapy: ☐ **Yes** ☐ **No** **Date:** _____ **Response:** _____

MRI report: ☐ **Yes** ☐ **No** **Date:** _____ **Results:** _____

Other previous therapies /response: _____ **Previous medications /response:** _____