HealthPartners®

Prior Authorization for Sacroiliac (SI) Injections to treat SI joint pain

Fax completed forms to **(952)853-8713.** Call Utilization Management (UM) at **(952)883-6333** with questions. Incomplete forms will be returned. **Submit clinical documentation** to support your request. Sign in at healthpartners.com/provider and use the Authorizations and referrals link to check the status of your prior authorization request.

Member information

First Name _____ MI _____ Last Name _____

HealthPartners ID # _____ DOB _____

Requester information

Form completed by: First Name _____ Last name _____

Your business name _____

Your business street address _____

Your business city _____ Your business state _____ Your business zip _____

Phone* _____ Fax** _____

Ordering provider information

Provider first name _____ Provider last name _____

Specialty _____ NPI _____

Clinic name _____

Clinic street address _____

Clinic city _____ Clinic state _____ Clinic zip _____

Clinic tax ID (claim may be rejected if incorrect) _____

Email _____ Phone* _____ Fax** _____

Procedural provider information

☐ *check box if same as **Ordering Provider Information** above*

Provider first name _____ Provider last name _____

Specialty _____ NPI _____

Clinic name _____

Clinic street address _____

Clinic city _____ Clinic state _____ Clinic zip _____

Clinic tax ID (claim may be rejected if incorrect) _____

Email _____ Phone* _____ Fax** _____

Facility site for procedure or surgery

Facility name _____

Facility street address _____

Facility City _____ Facility state _____ Facility zip _____

Billing tax ID (claim may be rejected if incorrect) _____

Phone* _____ Fax** _____

**Confidential voicemail required*
***For outcome notification*

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Procedure or surgery

Only include codes requiring prior authorization; other codes will not be addressed.

Primary diagnosis code _____ Description _____

Secondary diagnosis code _____ Description _____

Procedure code(s) _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

Procedure(s) or surgery description _____

_____

Proposed date of procedure _____ or ☐ TBD

Will waiting the standard review time seriously jeopardize member's health, life or ability to regain maximum functioning? ☐ Yes ☐ No

Clinical reason for urgency (not scheduling issues) _____

Please submit documentation that supports the medical necessity for this procedure, including severity, location, duration of pain and conservative treatment attempts.

Has the member completed at least 4 physical therapy visits over a course of 6 weeks or less, within the last 6 months, and for the current episode of pain? If yes, please submit PT notes. ☐ Yes ☐ No

Please indicate if injection is ☐ Therapeutic or ☐ Diagnostic.

Please select injection type:

☐ Right side, initial injection ☐ Right side, repeat injection

☐ Left side, initial injection ☐ Left side, repeat injection

Repeat SI Injections:

Diagnostic Injections: A diagnostic injection completed within 12 months of the previous diagnostic SI injection will be considered a repeat injection. If longer than 12 months have lapsed since previous diagnostic injection, criteria for an initial SI injection must be met.

Therapeutic Injections: A maximum of 4 therapeutic injections in a 12 month period are allowed. Check and date injections already received and submit clinical documentation indicating pain relief from previous clinical injections.

☐ First injection date: _____ ☐ Second injection date: _____

☐ Third injection date: _____ ☐ Fourth injection date: _____

Did the previous injection provide relief? ☐ Yes ☐ No

What was the percentage of pain relief? _____

Over what period of time did the member experience relief? _____