Custom Design Benefits

Date of Request: ____/____/_____

PAIN MANAGEMENT FORM

Patient Name: _____ **Member ID #** _____

Patient DOB: ____/____/_____ Patient Phone: (___) ____-_____ Different Last Name: _____

Ordering Physician: _____ Address: _____

City: _____ State: ____ Zip _____ Phone: (___) ____-_____ Fax: (___) ____-_____

Contact Person: _____ Fax: ( )____-_____Contact Phone: (___) ____-_____ Ext: _____

Physician Tax ID#: _____ NPI#: _____

FACILITY FOR SERVICE: Date of Service: / / Fax: ( ) -

Name: _____ Phone: (___) ____-_____

Address, City, State: _____

Facility Tax ID: _____ Facility NPI#: _____

Reason for Procedure: Diagnostic_____ Therapeutic _____ In Office _____ Out Patient _____

APPLICABLE AREA: Cervical ____ Thoracic ____ Lumbar ____ SI Joint ____ Hip____ Knee____

CPT Code	Level	ICD 10

What conservative treatments have been tried for the chief complaint/primary diagnosis being treated?

Physical Therapy _____ Chiropractor _____NSAIDS _____ Steroids _____ Medications _____ **ALL** _____

HISTORY/PHYSCIAL, OFFICE VISIT NOTES, AND ALL APPLICABLE DIAGNOSTIC TEST RESULTS MUST BE SUBMITTED TO SUPPORT REQUESTS FOR APPROVAL OF ALL INJECTIONS.

DATE OF LAST INJECTION	Type of injection	Level	% of Relief	Duration of Relief

PLEASE PROVIDE ALL CLINICAL DOCUMENTATION FOR PROCESSING.

FAX TO: MMFAX@CUSTOMDESIGNBENEFITS.COM OR FAX TO 513-389-2997

This authorization is not a guarantee of payment. Plan benefits are based on the patient's eligibility at the time of service. For questions on eligibility and benefits call 513-598-2929/800-598-2929

MM Form 2018

1117-17