MEDIAL BRANCH BLOCK INJECTIONS CERTIFICATION - Effective Oct. 1, 2013, benefit limits and eligibility guidelines were established for Facet/Medial Branch Block Injections. Medial Branch Block Injections must be performed by a qualified provider as required by Tennessee Acts of 2012, Public Chapter 961. This form must be submitted with your claim to have services considered for reimbursement.

SECTION I

Member Name _____ **Member I.D.** _____

Rendering Provider Name _____

Rendering Provider Type: (Check the type that applies)

- ☐ Advanced Practice Nurse
- ☐ Physician Assistant
- ☐ Physician

SECTION II

This Section must be completed by the Supervising Physician when the rendering Provider is an Advanced Practice Nurse or a Physician Assistant.

Supervising Provider Name _____

SECTION III

Procedure Code Billed _____ **Date of Procedure** _____

SECTION IV

(Check all that apply)

☐ I am the Advanced Practice Nurse who performed the interventional pain management procedure on the member and date noted above. Additionally, I certify that this procedure was performed in compliance with the requirements of T.C.A. § 63-7-126(f) and that the procedure was a medial branch block performed for diagnostic purposes only.

☐ I am the Physician Assistant who performed the interventional pain management procedure on the member and date noted above. Additionally, I certify that this procedure was performed in compliance with the requirements of T.C.A. § 63-19-107(5) and that the procedure was a medial branch block performed for diagnostic purposes only.

☐ I am a Physician and I supervised the Advanced Practice Nurse or Physician Assistant who performed the interventional pain management procedure on the member and date noted above. Additionally, I certify that this procedure was performed in compliance with the requirements of T.C.A. § 63-6-244 or T.C.A. § 63-9-121, as applicable, and that the procedure was medial branch block performed for diagnostic purposes only.

☐ I am the Physician who performed the interventional pain management procedure on the member and date noted above. Additionally, I certify that this procedure was performed in compliance with the requirements of T.C.A. § 63-6-244 or T.C.A. § 63-9-121, as applicable, and that the procedure was a medial branch block performed for diagnostic purposes only.

_____ Rendering Provider NPI # _____

RENDERING PROVIDER SIGNATURE DATE

_____

* SUPERVISING PHYSICIAN SIGNATURE DATE * SUPERVISING PHYSICIAN NPI # _____

* Supervising PHYSICIAN Signature, Signature Date, and NPI # must be inserted here if the RENDERING PROVIDER is an ADVANCED PRACTICE NURSE or a PHYSICIAN ASSISTANT.

Medial Branch Block Injections Certification 10-30-13