

Pain Management Procedure Questionnaire

THIS QUESTIONNAIRE IS PART OF THE APPLICATION, INCLUDING A RENEWAL APPLICATION, SUBMITTED BY OR ON BEHALF OF THE APPLICANT FOR THE PROPOSED INSURANCE. THE NOTICES, CONDITIONS, REPRESENTATIONS AND AUTHORIZATIONS CONTAINED IN SUCH APPLICATION ARE INCORPORATED INTO AND APPLY TO THIS QUESTIONNAIRE.

Applicant Name:

Expiring Policy Number (if applicable):

1. Please check either "YES" or "NO" for every procedure to indicate whether you plan to perform any of the following procedures in your current practice:

	Yes	No
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>
Blocks:		
Caudal Epidural Block	<input type="checkbox"/>	<input type="checkbox"/>
Celiac Plexus Block	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Epidural	<input type="checkbox"/>	<input type="checkbox"/>
Differential Spinal	<input type="checkbox"/>	<input type="checkbox"/>
Facet Joint Block:		
Cervical	<input type="checkbox"/>	<input type="checkbox"/>
Lumbar	<input type="checkbox"/>	<input type="checkbox"/>
Thoracic	<input type="checkbox"/>	<input type="checkbox"/>
Lumbar Epidural	<input type="checkbox"/>	<input type="checkbox"/>
Lumbar Sympathetic Block	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral Nerve Block	<input type="checkbox"/>	<input type="checkbox"/>
Retrolubar Block	<input type="checkbox"/>	<input type="checkbox"/>
Spinal Nerve Block	<input type="checkbox"/>	<input type="checkbox"/>
Stellate Ganglion Block	<input type="checkbox"/>	<input type="checkbox"/>
Sympathetic Nerve Block	<input type="checkbox"/>	<input type="checkbox"/>
Botox Injections	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Discograms	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Disk Nucleoplasty	<input type="checkbox"/>	<input type="checkbox"/>
Cordotomies	<input type="checkbox"/>	<input type="checkbox"/>
Cryoanalgesia	<input type="checkbox"/>	<input type="checkbox"/>
Dorsal Column Stimulator Implants/Reprogram	<input type="checkbox"/>	<input type="checkbox"/>
Epidural or Spinal Catheters	<input type="checkbox"/>	<input type="checkbox"/>
Fluoroscopy	<input type="checkbox"/>	<input type="checkbox"/>
Intra-Articular Block (Joint Injections)	<input type="checkbox"/>	<input type="checkbox"/>
Intradiscal Electrothermal Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Intravenous Regional Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>
Hypnosis	<input type="checkbox"/>	<input type="checkbox"/>
Lumbar Discograms	<input type="checkbox"/>	<input type="checkbox"/>
Lumbar Disk Nucleoplasty	<input type="checkbox"/>	<input type="checkbox"/>
Manipulation & Massage	<input type="checkbox"/>	<input type="checkbox"/>
Myofascial Trigger Point Injections	<input type="checkbox"/>	<input type="checkbox"/>
Nerve Root Injections	<input type="checkbox"/>	<input type="checkbox"/>
Percutaneous Discectomy	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Percutaneous Endoscopic Nerve Root Decompression	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral Nerve Stimulation	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Prolotherapy	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes," do you use Phenol?	<input type="checkbox"/>	<input type="checkbox"/>
Radio Frequency Nerve Ablation	<input type="checkbox"/>	<input type="checkbox"/>
Rapid Detoxification	<input type="checkbox"/>	<input type="checkbox"/>
Sphenopalatine Lesioning	<input type="checkbox"/>	<input type="checkbox"/>
Spinal Infusion Implants or Removal	<input type="checkbox"/>	<input type="checkbox"/>
Spinal Infusion Pumps Refilling & Reprograming	<input type="checkbox"/>	<input type="checkbox"/>
Spinal Stimulation Implants	<input type="checkbox"/>	<input type="checkbox"/>
Spinal Stimulation Programing	<input type="checkbox"/>	<input type="checkbox"/>
Thoracic Sympathectomies	<input type="checkbox"/>	<input type="checkbox"/>
Trigeminal Lesioning	<input type="checkbox"/>	<input type="checkbox"/>
Vertebroplasty	<input type="checkbox"/>	<input type="checkbox"/>
2. What percentage of your practice incorporates the procedures above?	_____	%
3. Where (which locations) is the insured practicing this type of surgery?		
4. Please list other procedures you perform that are not listed above:		
<p>Please provide proof of training/certification with an approved anesthesia program to the procedures that you have indicated above.</p>		

SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this questionnaire are true and complete.

The notices, conditions, representations and authorizations contained in the Application submitted by or on behalf of the Applicant for the proposed insurance, are incorporated into and apply to this questionnaire.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	