

**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 SIGNATURE      DATE      Rendering Provider NPI # \_\_\_\_\_

\_\_\_\_\_  
\* 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.