

# NEUROLOGY

## SUPPLEMENTAL QUESTIONNAIRE

Your Full Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
 (Please Print)

Directions: Please complete the following questions regarding your practice. If a question does not apply to your practice, state "N/A." Use the Remarks section if you need additional space or attach additional pages as necessary. **Your signature is required on page 5.**

### Section I: Interventional and Pain Management Procedures

1. Please indicate with an **X** which of the following procedures you perform and provide the estimated number that you have performed.

If you do not perform any of the procedures listed below, please check here.

| Procedure   | Estimated Number You Have Performed | Location(s) Where Performed  |
|---|-------------------------------------|--|
| <input type="checkbox"/> Epidural Injection<br><input type="checkbox"/> Caudal<br><input type="checkbox"/> Cervical<br><input type="checkbox"/> Lumbar<br><input type="checkbox"/> Thoracic<br><input type="checkbox"/> Steroid Only<br><input type="checkbox"/> Local Anesthetic With or Without Steroid<br><input type="checkbox"/> Other: _____    |                                     | <input type="checkbox"/> Hospital/Hospital Surgery Center<br><input type="checkbox"/> Accredited Surgery Center (nonhospital)*<br><input type="checkbox"/> Nonaccredited Facility With Crash Cart<br><input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Facet Joint Injection<br><input type="checkbox"/> Cervical<br><input type="checkbox"/> Lumbar<br><input type="checkbox"/> Thoracic   |                                     | <input type="checkbox"/> Hospital/Hospital Surgery Center<br><input type="checkbox"/> Accredited Surgery Center (nonhospital)*<br><input type="checkbox"/> Nonaccredited Facility With Crash Cart<br><input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Sympathetic Nerve Injection<br><input type="checkbox"/> Celiac Plexus<br><input type="checkbox"/> Lumbar<br><input type="checkbox"/> Stellate Ganglion<br><input type="checkbox"/> Other: _____<br><input type="checkbox"/> Local Anesthetic<br><input type="checkbox"/> Neurolytic<br><input type="checkbox"/> Other: _____ |                                     | <input type="checkbox"/> Hospital/Hospital Surgery Center<br><input type="checkbox"/> Accredited Surgery Center (nonhospital)*<br><input type="checkbox"/> Nonaccredited Facility With Crash Cart<br><input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Discography<br><input type="checkbox"/> Cervical<br><input type="checkbox"/> Lumbar<br><input type="checkbox"/> Thoracic   |                                     | <input type="checkbox"/> Hospital/Hospital Surgery Center<br><input type="checkbox"/> Accredited Surgery Center (nonhospital)*<br><input type="checkbox"/> Nonaccredited Facility With Crash Cart<br><input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Epidural Lysis of Adhesions  |                                     | <input type="checkbox"/> Hospital/Hospital Surgery Center<br><input type="checkbox"/> Accredited Surgery Center (nonhospital)*<br><input type="checkbox"/> Nonaccredited Facility With Crash Cart<br><input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Epidural/Spinal Endoscopy  |                                     | <input type="checkbox"/> Hospital/Hospital Surgery Center<br><input type="checkbox"/> Accredited Surgery Center (nonhospital)*<br><input type="checkbox"/> Nonaccredited Facility With Crash Cart<br><input type="checkbox"/> Other: _____ |

| Procedure  | Estimated Number You Have Performed | Location(s) Where Performed  |
|--|-------------------------------------|--|
| <input type="checkbox"/> Epidural/Spinal Catheter Placement  |                                     | <input type="checkbox"/> Hospital/Hospital Surgery Center<br><input type="checkbox"/> Accredited Surgery Center (nonhospital)*<br><input type="checkbox"/> Nonaccredited Facility With Crash Cart<br><input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Single-Shot Intrathecal Injection   |                                     | <input type="checkbox"/> Hospital/Hospital Surgery Center<br><input type="checkbox"/> Accredited Surgery Center (nonhospital)*<br><input type="checkbox"/> Nonaccredited Facility With Crash Cart<br><input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Intrathecal/Epidural Infusion Pump Implant  |                                     | <input type="checkbox"/> Hospital/Hospital Surgery Center<br><input type="checkbox"/> Accredited Surgery Center (nonhospital)*<br><input type="checkbox"/> Nonaccredited Facility With Crash Cart<br><input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Intrathecal/Epidural Infusion Pump Refilling and Reprogramming  |                                     | <input type="checkbox"/> Hospital/Hospital Surgery Center<br><input type="checkbox"/> Accredited Surgery Center (nonhospital)*<br><input type="checkbox"/> Nonaccredited Facility With Crash Cart<br><input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Fluoroscopy   |                                     | <input type="checkbox"/> Hospital/Hospital Surgery Center<br><input type="checkbox"/> Accredited Surgery Center (nonhospital)*<br><input type="checkbox"/> Nonaccredited Facility With Crash Cart<br><input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Lumbar Discograms   |                                     | <input type="checkbox"/> Hospital/Hospital Surgery Center<br><input type="checkbox"/> Accredited Surgery Center (nonhospital)*<br><input type="checkbox"/> Nonaccredited Facility With Crash Cart<br><input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Neuroablative Techniques<br><input type="checkbox"/> Cryoneurolysis (aka Cryoanalgesia or Cryoneuroablation)<br><input type="checkbox"/> Radiofrequency Nerve Ablation<br><input type="checkbox"/> Other: _____ |                                     | <input type="checkbox"/> Hospital/Hospital Surgery Center<br><input type="checkbox"/> Accredited Surgery Center (nonhospital)*<br><input type="checkbox"/> Nonaccredited Facility With Crash Cart<br><input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Neurostimulation Device Implants<br><input type="checkbox"/> Peripheral Nerve Stimulation<br><input type="checkbox"/> Spinal Cord Stimulation   |                                     | <input type="checkbox"/> Hospital/Hospital Surgery Center<br><input type="checkbox"/> Accredited Surgery Center (nonhospital)*<br><input type="checkbox"/> Nonaccredited Facility With Crash Cart<br><input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Neurostimulation Device Reprogramming<br><input type="checkbox"/> Peripheral Nerve Stimulation<br><input type="checkbox"/> Spinal Cord Stimulation  |                                     | <input type="checkbox"/> Hospital/Hospital Surgery Center<br><input type="checkbox"/> Accredited Surgery Center (nonhospital)*<br><input type="checkbox"/> Nonaccredited Facility With Crash Cart<br><input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Nucleoplasty  |                                     | <input type="checkbox"/> Hospital/Hospital Surgery Center<br><input type="checkbox"/> Accredited Surgery Center (nonhospital)*<br><input type="checkbox"/> Nonaccredited Facility With Crash Cart<br><input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Percutaneous Lumbar Discectomy  |                                     | <input type="checkbox"/> Hospital/Hospital Surgery Center<br><input type="checkbox"/> Accredited Surgery Center (nonhospital)*<br><input type="checkbox"/> Nonaccredited Facility With Crash Cart<br><input type="checkbox"/> Other: _____ |





**For California and Rhode Island Physicians Only**

I represent and warrant the truth of my statements and information mentioned herein, and that I have not withheld any information that may be relevant to my coverage. I agree to notify NORCAL Mutual Insurance Company immediately if my practice changes in any way and of any change in the information contained on this questionnaire.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

**For Alaska Physicians Only**

I represent the truth of my statements and information mentioned herein, and that I have not withheld any information that may be relevant to my coverage. I agree to notify NORCAL Mutual Insurance Company immediately if my practice changes in any way and of any change in the information contained on this questionnaire.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name