Innovative Care Management

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Telephone: (503) 654-9447 Fax: (503) 654-8570 Toll Free: 1-800-862-3338
Healthcare savings and satisfaction through innovation and respect.

Requested by: _____ Location: _____

Phone: _____ Fax: _____

Patient Name: _____ DOB: _____

Employer/Plan Name: _____ Plan ID: _____

Please indicate if this request is considered Urgent under Department of Labor Definitions: ❑

Please indicate the ***date of service*** for this pending request: _____ or ❑ Not Scheduled

Please indicate the type of service for this pending request:

❑ Outpatient ❑ Inpatient Requested Length of Stay: _____

Facility: _____ Phone: _____

Physician: _____ Phone: _____ Fax: _____

Physician Mailing Address: _____

Please indicate the service(s) for which you are seeking preauthorization:

CPT: _____ Description: _____
CPT: _____ Description: _____
CPT: _____ Description: _____
CPT: _____ Description: _____
CPT: _____ Description: _____

Please indicate the diagnoses related to this request:

ICD: _____ Description: _____
ICD: _____ Description: _____
ICD: _____ Description: _____
ICD: _____ Description: _____
ICD: _____ Description: _____

Please fax the completed questionnaire and **pertinent clinical information** to 503-654-8570. Suggested items to include in the submission:

1. Recent History & Physical
2. Related Imaging Studies
3. Related Operative Reports
4. Written Prescription (for DME, Physical Therapy, Occupational Therapy, and Home Health requests)
5. Other pertinent clinical information that substantiates medical necessity for the requested service(s)