Innovative Care Management

ICM Preauthorization Request Form

Submit completed forms and clinical information outlined below by upload* to our secure server found through the red "click to upload files" button at **https://www.innovativecare.com/**, by fax to **503-654-8570, or** by secure email to **onlineprecert@innovativecare.com**.

*If uploading, upload only one file per patient (PDF only) and ensure that uploaded information includes basic patient identifying information.

"A claim involving urgent care is generally a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could **seriously jeopardize the life or health of the claimant** or the **ability of the claimant to regain maximum function;** or, in the opinion of the physician with knowledge of the claimant's medical condition, would subject the claimant to **severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim**."

❑ I certify that this request meets the above definition for Urgent processing according to the Department of Labor.

Patient Information		
Last Name	First Name	Date of Birth
Employer/Plan Name		Plan ID
Address, City, State, Zip		Phone
Subscriber Name (if different than patient)		Subscriber Relationship

Your Contact Information (Submitted by)		
Name	Phone	Fax
Email		

Provider Information	
Provider	Specialty
Phone	Fax
Provider Primary Address (include suite # if applicable)	NPI

Facility Information	
Facility	
Phone	Fax
Facility Address (include suite # if applicable)	NPI

See next page for service details

Joint Arthroplasty Service Request		
Date of Service		❑ Not Scheduled
Type of Service	❑ Inpatient	❑ Outpatient
Description of Service(s) Requested. Please indicate the joint of this arthroplasty (e.g., left hip)		
CPT Code(s)	ICD Code(s)	

Additional Information

Is the planned procedure a custom joint replacement (implant individually manufactured for this patient)? ❑ Yes ❑ No

If yes, implant Product Name: _____

Manufacturer: _____

Is the planned procedure using a robotic or computer assist? ❑ Yes ❑ No

If yes, will it be billed separately? ❑Yes ❑ No CPT code(s):_____

Name of procedure/system to be used (e.g. MAKOplasty):_____

Is the planned procedure using Patient-specific Instrumentation (individually manufactured for this patient)? ❑ Yes ❑ No

If yes, instrumentation product name: _____

Manufacturer:_____

Clinical Information: For General Preauthorization requests, please include the following information as appropriate:

☐ Most recent **History & Physical**

☐ Most recent **office visit note(s)** documenting symptoms and conservative therapy

☐ Related i**maging reports**, i.e, X-ray, MRI, CT

☐ Any other **pertinent clinical information** that substantiates medical necessity for the requested service(s)

Note: Please do not resend clinicals if already submitted by separate fax.

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ICM has multiple service-specific forms that may provide additional details. Please browse our full selection of forms at https://www.innovativecare.com/preauthorization-request/