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

Spinal Fusion Service Request		
Date of Service ❑ Not Scheduled	❑ Inpatient	❑ Outpatient
Description of Service(s) Requested, including level(s) of the spinal surgery (e.g. C2-C3):		
CPT Code(s)	ICD Code(s)	

Graft Material: ***We require documentation of the proposed type of graft material***. Please identify the type of graft material(s) to be used below. If a combination of materials will be used, please check all appropriate boxes and associated fields.

❑ **Synthetic Graft Material** e.g. bone morphogenic protein, bone void fillers, ceramic or polymer-based, etc.

Product Name(s):______________________Manufacturer(s):______________________

❑ **Allograft** e.g. cadaver, demineralized bone matrix, cancellous, morselized bone, etc.

Type(s):______________________

Product Name(s):______________________Manufacturer(s):______________________

❑ **Autograft (Autologous)** – Patient's own bone

Please note: If different or additional graft material(s) not preauthorized are used at the time of surgery, the additional graft material(s) may be reviewed for medical necessity retrospectively and applicable plan language (including Experimental & Investigational exclusions) will be considered prior to claims payment. We ***strongly*** encourage pre-service review of all graft material.

Intraoperative Nerve Monitoring Service Request

Will Intraoperative Nerve Monitoring (IONM) be performed during this procedure: ❑ Yes ❑ No (If no, stop here and submit)

Will the **requesting surgeon** be performing Intraoperative Nerve Monitoring (IONM)? ❑ Yes ❑ No

If **yes**, what type of nerve monitoring (Evoked Potentials, Electromyographic-EMG Monitoring, EEG Monitoring, etc.):

CPT:__________Description:______________________

CPT:__________Description:______________________

CPT:__________Description:______________________

CPT:__________Description:______________________

If **no**, IONM Provider Name:______________________Phone:__________

Address:______________________Fax:__________

Note: If the requesting surgeon will not be billing for IONM, but an outside entity will be, the outside entity will need to obtain preauthorization for the IONM services.

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 as applicable
☐ Most recent **imaging reports**, e.g., X-ray, MRI, CT
☐ Related **Operative Reports**
☐ Any other **pertinent clinical information** that substantiates medical necessity for the requested service(s)

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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/