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

Service Request

Date of Service ❑ Not Scheduled

❑ Inpatient ❑ Residential ❑ SNF ❑ Outpatient Surgery

❑ Other (LTAC, IPR, Inpatient Hospice):_____ Requested Length of Stay: _____

Outpatient Services

❑Imaging ❑Laboratory Testing ❑ PHP ❑ IOP ❑ Other:_____

Number of Sessions:_____ Duration:_____ Frequency:_____

Therapies

❑ Physical Therapy ❑ Speech Therapy ❑ Occupational Therapy

❑ Acupuncture ❑ Chiropractic Treatment ❑ Applied Behavior Analysis (ABA)

❑ Home Health (specify type: RN, MSW, etc):_____ ❑ Other:_____

Location: ❑ Outpatient/facility-based ❑ Home

Number of Sessions:_____ Duration:_____ Frequency:_____

Date of Initial Evaluation for this condition:_____

DME

❑ Rental Rental Price*: _____ ❑ Purchase Purchase Price*:_____

Duration:_____

*Certain plans only require prior authorization for DME over a certain dollar amount. In order to determine if the request requires prior-authorization, please include rental or purchase price.

Medications

Requested number of infusions/injections:_____ Duration:_____ Frequency:_____

Is this "buy & bill"? ☐ Yes ☐ No

Description of Service(s) Requested

CPT Code(s)	ICD Code(s)

Clinical Information: For General Preauthorization requests, please as appropriate:

- ☐ Most recent **History & Physical**
- ☐ Most recent **office visit note(s)** documenting symptoms and conservative therapy as applicable
- ☐ Related **imaging reports**, i.e, X-ray, MRI, CT
- ☐ Related **laboratory reports**
- ☐ Related **Operative Reports**
- ☐ Written **Prescription** for DME, Therapies, etc. as applicable
- ☐ 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/