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

See next page for service details

ABA Service Request

Start Date of Service _____ or ☐ Not Scheduled Requested Auth Period (typically six months): _____

How long has the patient received ABA services? _____ or ☐ Onset of Therapy

Treatment Code(s):

☐ 97153 _____ Hours per ☐ Week or ☐ Month **and** _____ Units per auth period

☐ 97154 _____ Hours per ☐ Week or ☐ Month **and** _____ Units per auth period

☐ 97155 _____ Hours per ☐ Week or ☐ Month **and** _____ Units per auth period

☐ 97156 _____ Hours per ☐ Week or ☐ Month **and** _____ Units per auth period

☐ 97157 _____ Hours per ☐ Week or ☐ Month **and** _____ Units per auth period

☐ 97158 _____ Hours per ☐ Week or ☐ Month **and** _____ Units per auth period

☐ 0373T _____ Hours per ☐ Week or ☐ Month **and** _____ Units per auth period

☐ Other code(s) _____: _____ Hours per ☐ Week or ☐ Month **and** _____ Units per auth period

Assessment Code(s) per auth period (six months):

☐ 97151 _____ Hours and _____ Units

☐ 97152 _____ Hours and _____ Units

☐ 0362T _____ Hours and _____ Units

Aside from the requested services, what other services is the patient receiving:

☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy

☐ Primary Care (e.g., Pediatrician)

☐ Services through the school system

☐ Mental Health Services ☐ Medication Management

Description of Services Requested:

ICD Code(s):

1. _____

2. _____

3. _____

The following clinical information is required for review:

- Written **prescription** for ABA Therapy
- Written documentation of initial **Autism diagnosis** from diagnosing provider (e.g., pediatrician, neurologist, psychologist, psychiatrist)
- Initial & most recent **ABA evaluation** including standardized assessments (e.g., Vineland, VB-MAPP etc.)
- Clearly defined treatment plan
- 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/