



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

Back Injections Service Request				
Date of Service _____			<input type="checkbox"/> Not Scheduled	
Please indicate the type of injection requested:				
<input type="checkbox"/> Epidural Steroid Injection		<input type="checkbox"/> SI Joint Injection		<input type="checkbox"/> Medial Branch Block
<input type="checkbox"/> Facet Injection		<input type="checkbox"/> Trigger Point Injection		<input type="checkbox"/> Radiofrequency ablation (RFA)
Description of Service(s) Requested				
<i>Note: If you are requesting authorization to separately bill ultrasound/radiologic guidance, fluoroscopy, or epidurography, please be advised that these services will need to be sent to a physician review for determination and will delay the processing of your request. If you are not separately billing for these codes, please do not include on this request form.</i>				
CPT Code(s)			ICD Code(s)	
Is the requested injection: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral				
Please indicate the level(s) of this injection (e.g. L5-S1): _____				
Additional Information				
Does the patient have any of the following conditions?		<input type="checkbox"/> Coagulopathy <input type="checkbox"/> Injection site infection <input type="checkbox"/> Increased Intracranial pressure <input type="checkbox"/> Epidural metastases <input type="checkbox"/> Septicemia <input type="checkbox"/> None of the above conditions		
Has the patient been treated with anti-inflammatory drugs? (NSAIDS, etc.)		<input type="checkbox"/> Yes <input type="checkbox"/> No How long? _____		
Has the patient been treated with conservative therapies?		<input type="checkbox"/> Yes (indicate length of time in space) Physical therapy _____ Chiropractic _____ Activity modification _____ <input type="checkbox"/> No		
Has the patient had a prior spinal injection at this level?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Please provide the dates, levels, response, and duration for injections in the last 12 months:				
Note: if this is the first injection, please check here: <input type="checkbox"/>				
Date	Injection Type (e.g. facet, ESI, etc.)	Level(s)	Response (% relief)	Duration (week, month, etc)

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

- History & Physical** prior to initial injection
- Most recent **office visit note(s)** documenting care and noting specifics of above pertinent findings
- Most recent **imaging reports**, including MR or CT
- 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/>