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

Intraoperative Nerve Monitoring Service Request

Date of Service ❑ Not Scheduled

Primary surgical procedure:_____

Name of surgeon:_____ Phone:_____

Address:_____ Fax:_____

❑ Inpatient ❑ Outpatient

Description of Service(s) Requested (Evoked Potentials, Electromyographic-EMG Monitoring, EEG Monitoring, etc):

CPT:_____ Description:_____

CPT:_____ Description:_____

CPT:_____ Description:_____

CPT:_____ Description:_____

CPT:_____ Description:_____

CPT:_____ Description:_____

CPT:_____ Description:_____

ICD Code(s)

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**, i.e, 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/