



## 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](mailto: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**

| Service Request  |  |
|--|--|
| Date of Service _____  | <input type="checkbox"/> Not Scheduled |
| <input type="checkbox"/> Inpatient <input type="checkbox"/> Residential <input type="checkbox"/> SNF <input type="checkbox"/> Outpatient Surgery<br><input type="checkbox"/> Other (LTAC, IPR, Inpatient Hospice): _____ Requested Length of Stay: _____   |  |
| <b>Outpatient Services</b>   |  |
| <input type="checkbox"/> Imaging <input type="checkbox"/> Laboratory Testing <input type="checkbox"/> PHP <input type="checkbox"/> IOP <input type="checkbox"/> Other: _____<br>Number of Sessions: _____ Duration: _____ Frequency: _____   |  |
| <b>Therapies</b>   |  |
| <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Occupational Therapy<br><input type="checkbox"/> Acupuncture <input type="checkbox"/> Chiropractic Treatment <input type="checkbox"/> Applied Behavior Analysis (ABA)<br><input type="checkbox"/> Home Health (specify type: RN, MSW, etc): _____ <input type="checkbox"/> Other: _____<br>Location: <input type="checkbox"/> Outpatient/facility-based <input type="checkbox"/> Home<br>Number of Sessions: _____ Duration: _____ Frequency: _____<br>Date of Initial Evaluation for this condition: _____ |  |
| <b>DME</b>   |  |
| <input type="checkbox"/> Rental      Rental Price*: _____ <input type="checkbox"/> Purchase      Purchase Price*: _____<br>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.  |  |
| <b>Medications</b>   |  |
| Requested number of infusions/injections: _____ Duration: _____ Frequency: _____<br>Is this "buy & bill"? <input type="checkbox"/> Yes <input type="checkbox"/> 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/>