



## 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	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 _____	<input type="checkbox"/> Not Scheduled
<input type="checkbox"/> Inpatient <input type="checkbox"/> Residential <input type="checkbox"/> SNF <input type="checkbox"/> Outpatient Surgery <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: _____ Number of Sessions: _____ Duration: _____ Frequency: _____	
<b>Therapies</b>	
<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Acupuncture <input type="checkbox"/> Chiropractic Treatment <input type="checkbox"/> Other: _____ <input type="checkbox"/> Home Health (specify type: RN, MSW, etc): _____ Location: <input type="checkbox"/> Outpatient/facility-based <input type="checkbox"/> Home Number of Sessions: _____ Duration: _____ Frequency: _____ Date of Initial Evaluation for this condition: _____	
<b>DME</b>	
<input type="checkbox"/> Rental      Rental Price*: _____ <input type="checkbox"/> 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.	
<b>Medications</b>	
Requested number of infusions/injections: _____ Duration: _____ Frequency: _____ 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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- Fax **503-654-8570**

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/>