INJURY MANAGEMENT ORGANIZATION, INC.

Preauthorization Request Form (IMO Network Department)

Tel: 214-217-5939 or 888-466-6381 | Fax: 214-217-5937 or 877-946-6638
Submit Request Online: www.injurymanagement.com

CLAIM PROFILE			
PATIENT'S NAME:		PHONE:	
ADDRESS:	CITY:	STATE:	ZIP:
DOI:	DOB:	SSN (last 4 digits):	
EMPLOYER:		CLAIM #:	
INSURANCE CARRIER:		ADJUSTER NAME:	
Employee Network Participation: IMO Med-Select Network® ⬭ Non-Network ⬭			
TREATING PROVIDER ***(approved by network)***			
PROVIDER NAME:		PHONE:	FAX:
ADDRESS:	CITY:	STATE:	ZIP:
TAX ID #:	**NPI #:**	CONTACT NAME:	
Email address for determination letters:			
REQUESTING PROVIDER ***(seeking authorization)***			
PROVIDER NAME:		PHONE:	FAX:
ADDRESS:	CITY:	STATE:	ZIP:
TAX ID #:	**NPI #:**	CONTACT NAME:	
Email address for determination letters:			
FACILITY INFORMATION ***(location where requested service would be performed)***			
FACILITY NAME:		PHONE:	FAX:
ADDRESS:	CITY:	STATE:	ZIP:
TAX ID #:	**NPI #:**	CONTACT NAME:	
Email address for determination letters:			
SERVICE REQUEST / TYPE OF REVIEW			
REQUESTED PROCEDURE & BODY PART:			
EXPECTED DATES OF SERVICE:		IN-PATIENT (#_____ of days) **OR** OUT-PATIENT	
FREQUENCY & DURATION:		ICD-9 CODE(s):	
Initial Review ⬭ **Concurrent** ⬭ **Appeal/Reconsideration** ⬭		CPT CODE(s):	
PEER-TO-PEER CONTACT NAME *If other than requestor:*		PHONE / HOURS:	

Please include all supporting clinical documentation to validate this request.