



MANAGED HEALTHCARE NORTHWEST, INC.

422 E. BURNSIDE, SUITE 215, PO BOX 4 629, PORTLAND, OREGON 97208-4629

(503) 413-5800 Fax (503) 413-5801

CAREMARK PPO PRECERTIFICATION REQUEST FORM

CLEARLY COMPLETE REQUEST AND FAX WITH CURRENT CHART NOTES
AND DIAGNOSTIC REPORTS TO: 503-413-5864

PLEASE ALLOW 48 HOURS FOR DETERMINATIONS WHICH WILL BE FAXED TO YOU.

Authorization cannot be given unless all necessary information is provided.

DATE: _____

PRIMARY INSURANCE/SUBSCRIBER INFORMATION

Group Number: _____ Group Name: _____ Subscriber ID: _____
Subscriber Name: _____ Patients relationship to Insured: Insured Spouse Dependent
Secondary Insurance Company: _____ Phone: _____

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Sex: M or F
Phone: _____ Address: _____ City, St. Zip: _____

ORDERING PHYSICIAN

Physician: _____ Tax ID: _____
Contact Person: _____ Phone: _____ Fax: _____ On MHN Panel: Y or N
Clinic Name: _____ Address: _____
Date of Procedure: _____ Outpatient Inpatient # of Days Requested if inpatient: _____

DIAGNOSIS AND PROCEDURE

Dx Description:

ICD-9 Code:

Procedure or DME Item:

CPT or HCPCS Code:

Spinal Level: _____ Right Side Left Side

FACILITY INFORMATION

Facility: _____ Tax ID: _____ On MHN Panel: Y or N
Contact Person: _____ Phone: _____ Fax: _____
Address: _____

DME PROVIDERS

Provider: _____ Tax ID: _____ On MHN Panel: Y or N
Contact Person: _____ Phone: _____ Fax: _____
Address: _____
Rental: Purchase: If Rental # of Days: _____ Date or Rental/Purchase: _____