



# MANAGED HEALTHCARE NORTHWEST, INC.

422 E. BURNSIDE, SUITE 215, PO BOX 4629, 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: \_\_\_\_\_ or 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: \_\_\_\_\_