



MANAGED HEALTHCARE NORTHWEST, INC.

1120 N.W. 20TH, SUITE 200 PORTLAND, OREGON 97209-1539
(503) 413-5800 FAX (503) 413-5864

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: _____