



**MANAGED HEALTHCARE NORTHWEST, INC.**

422 East Burnside Street, Ste. 215, P.O. Box 4629, PORTLAND, OREGON 97208-4629  
(503) 413-5800 Fax (503) 413-5801

**CAREMARK COMP / CAREMARK PPO PRECERTIFICATION REQUEST FORM**

DATE: \_\_\_\_\_

**INSURANCE INFORMATION**

**CAREMARK COMP:**

Claim Number \_\_\_\_\_

Date of Injury \_\_\_\_\_

Payor: \_\_\_\_\_

Employer: \_\_\_\_\_

SSN: \_\_\_\_\_

Attending Physician: \_\_\_\_\_

**CAREMARK PPO:**

Group Number: \_\_\_\_\_

Group Name: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

SSN: \_\_\_\_\_

Patients relationship to Insured:  
(please circle) Insured Spouse Dependent

Patient's Name (Last, First): \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone #: ( ) \_\_\_\_\_ Sex:  M  F DOB: \_\_\_\_\_

Physician's Name (last, first) \_\_\_\_\_

Tax ID: \_\_\_\_\_ Clinic Name: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_ Panel: Y N

Facility to be used for procedure: \_\_\_\_\_ Panel: Y N

*If not on panel:* Address: \_\_\_\_\_

Phone#: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ICD-9 Code: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Procedure(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CPT Code: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Right Side:  Left Side:  If spinal, which level: \_\_\_\_\_

Date of Procedure: \_\_\_\_\_ OR To be scheduled: \_\_\_\_\_

Outpatient  Inpatient  If inpatient, number of days requested \_\_\_\_\_

**PLEASE FILL OUT REQUEST FORM AND FAX BACK WITH  
CURRENT CHART NOTES AND DIAGNOSTIC REPORTS TO:  
503-413-5864**

**No authorization can be given unless all necessary information is provided.**