PRINT

**MANAGED HEALTHCARE NORTHWEST**, INC.
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# 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 ☐ F
Phone: _____Address: _____City, St. Zip: _____

## ORDERING PHYSICIAN

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

## DIAGNOSIS AND PROCEDURE

| Dx Description: | Procedure or DME Item: |
|---|---|
| Current ICD-CM Code: | CPT or HCPCS Code: |

Spinal Level: ☐ Right Side ☐ Left Side

## FACILITY INFORMATION

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

## DME PROVIDERS

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