Itasca Medical Care (IMCare) Authorization Request

Submission of this form does not guarantee approval. Forms submitted with incomplete data cannot be reviewed and will be returned to your office. Benefits are subject to eligibility at the time service is rendered. ALL OUT-OF-NETWORK provider requests require a referral from an in-network provider.

IMCare will be unable to make a determination until relevant medical records are submitted with this form. At minimum submit the H&P or visit note at which the referral was made. Fax completed authorization request and supporting documentation to 218-327-5545.

☐ Standard Request ☐ Expedited Request

Expedited requests are to be used for pre-service requests on cases in which following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

☐ Work Comp/Date of Injury:_____ ☐ Motor Vehicle Accident/Date of Injury: _____

MEMBER INFORMATION

Name: _____ Date of Request: _____

Member ID Number: _____ DOB: _____

Member Phone: _____

REFERRED BY

Referring Provider:_____ Facility: _____

Phone Number:_____ Fax Number: _____

Address: _____ _____ _____ _____

City State Zip Code

☐ CD Rule 25 Agency: _____ ☐ **MH Rule 5 Agency:** _____

REFERRED TO

Provider Name:_____ Phone Number: _____

Facility:_____ Fax Number: _____

NPI# Provider:_____ NPI# Facility: _____

Address: _____ _____ _____ _____

City State Zip Code

Contact Person Name/Phone Number: _____

Date of Service/Admit: _____ **Discharge:**_____ **# of Visits:** _____

REASON FOR AUTHORIZATION

☐ Inpatient Stay ☐ Observation Stay ☐ Outpatient Clinic Visit(s) ☐ Outpatient Surgery/Procedure

☐ Laboratory ☐ Chemical Dependency per Diem: _____

CPT/HCPCS Code(s): _____ _____ _____ _____

ICD 10 Diagnosis Code(s): _____ _____ _____ _____

Medical Information:_____

IMCare Office Use Only

☐ Approved ☐ Not Approved _____ _____

Medical Director/QI Nurse Signature Date

Comments/Request: _____

Reason for Denial: _____

Revised 08/28/20