INJURY MANAGEMENT ORGANIZATION, INC.

Pre-Authorization Request Form (Network)

Tel: 214-217-5939 or 888-466-6381 | Fax: 214-217-5937 or 877-946-6638
Submit Request Online: www.injurymanagement.com

CLAIM PROFILE			
PATIENT'S NAME:		PHONE:	
ADDRESS:	CITY:	STATE:	ZIP:
DOI:	DOB:	SSN (last 4 digits):	
EMPLOYER:		CLAIM #:	
INSURANCE CARRIER:		ADJUSTER NAME:	
Employee Network Participation: 1305 Certified Network ⬭ 504 ⬭ None ⬭			

TREATING PROVIDER *(approved by TDI)*			
PROVIDER NAME:		PHONE:	FAX:
ADDRESS:	CITY:	STATE:	ZIP:
TAX ID #:	**NPI #:**	CONTACT NAME:	
Email address for determination letters:			

REQUESTING PROVIDER *(seeking authorization)*			
PROVIDER NAME:		PHONE:	FAX:
ADDRESS:	CITY:	STATE:	ZIP:
TAX ID #:	**NPI #:**	CONTACT NAME:	
Email address for determination letters:			

FACILITY INFORMATION *(location where requested service would be performed)*			
FACILITY NAME:		PHONE:	FAX:
ADDRESS:	CITY:	STATE:	ZIP:
TAX ID #:	**NPI #:**	CONTACT NAME:	
Email address for determination letters:			

SERVICE REQUEST / TYPE OF REVIEW	
REQUESTED PROCEDURE / BODY PART:	
EXPECTED DATES OF SERVICE:	IN-PATIENT (#_____ of days) **OR** OUT-PATIENT
FREQUENCY / DURATION:	ICD-9 CODE(s):
Initial Review ⬭ **Concurrent** ⬭ **Appeal/Reconsideration** ⬭	CPT CODE(s):
PEER-TO-PEER CONTACT NAME *If other than requestor:*	PHONE / HOURS:

Please include all supporting clinical documentation to validate this request.