INJURY MANAGEMENT ORGANIZATION, INC.

Preauthorization Request Form

Tel: 713-339-1268 or 877-789-0041 | Fax: 713-974-1962 or 877-974-1962

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 / PHYSICIAN TO PERFORM PROCEDURE:		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:	PHYSICAL THERAPY: YES ⬭ NO ⬭ GROUP SETTING ⬭ OR INDIVIDUAL ⬭	
MEDICATION NAME:	QUANTITY:	REFILLS #:
FREQUENCY & DURATION:	IN-PATIENT (#_____ of days) **OR** OUT-PATIENT ⬭	
ICD-10 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.