



**INJURY MANAGEMENT ORGANIZATION, INC.**  
**Preauthorization Request Form**

Tel: 214-217-5939 or 888-466-6381 | Fax: 214-217-5937 or 877-946-6638

Submit Request Online: [www.injurymanagement.com](http://www.injurymanagement.com)

CLAIM PROFILE			
<b>PATIENT'S NAME:</b>		PHONE:	
ADDRESS:	CITY:	STATE:	ZIP:
DOI:	DOB:	SSN (last 4 digits):	
<b>EMPLOYER:</b>		CLAIM #:	
<b>INSURANCE CARRIER:</b>		ADJUSTER NAME:	
Employee Network Participation: 1305 Certified Network <input type="radio"/> 504 <input type="radio"/> None <input type="radio"/>			
TREATING PROVIDER (approved by TDI)			
<b>PROVIDER NAME:</b>		PHONE:	FAX:
ADDRESS:	CITY:	STATE:	ZIP:
TAX ID #:	NPI #:	CONTACT NAME:	
Email address for determination letters:			
REQUESTING PROVIDER (seeking authorization)			
<b>PROVIDER NAME:</b>		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)			
<b>FACILITY / PHYSICIAN TO PERFORM PROCEDURE:</b>		PHONE:	FAX:
ADDRESS:	CITY:	STATE:	ZIP:
TAX ID #:	NPI #:	CONTACT NAME:	
Email address for determination letters:			
SERVICE REQUEST / TYPE OF REVIEW			
<b>REQUESTED PROCEDURE &amp; BODY PART:</b>			
<b>EXPECTED DATES OF SERVICE:</b>		PHYSICAL THERAPY: YES <input type="radio"/> NO <input type="radio"/>	
MEDICATION NAME:		GROUP SETTING <input type="radio"/> OR INDIVIDUAL <input type="radio"/>	
FREQUENCY & DURATION:		QUANTITY:	REFILLS #:
<b>ICD-10 CODE(S):</b>		IN-PATIENT (# ____ of days) <b>OR</b> OUT-PATIENT <input type="radio"/>	
Initial Review <input type="radio"/> Concurrent <input type="radio"/> Appeal/Reconsideration <input type="radio"/>		<b>CPT CODE(S):</b>	
PEER-TO-PEER CONTACT NAME <i>If other than requestor:</i>		PHONE / HOURS:	

**Please include all supporting clinical documentation to validate this request.**

*Revised 4.17.17 | IMO Network Dept. | Confidential*