



INJURY MANAGEMENT ORGANIZATION, INC.
Preauthorization Request Form

Tel: 972-404-8133 or 888-645-1200 | Fax: 972-991-5572 or 888-275-9946

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 <input type="radio"/> 504 <input type="radio"/> None <input type="radio"/>			
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 <input type="radio"/> NO <input type="radio"/>	
MEDICATION NAME:		GROUP SETTING <input type="radio"/> OR INDIVIDUAL <input type="radio"/>	
FREQUENCY & DURATION:		QUANTITY:	REFILLS #:
ICD-10 CODE(S):		IN-PATIENT (# ____ of days) OR OUT-PATIENT <input type="radio"/>	
Initial Review <input type="radio"/> Concurrent <input type="radio"/> Appeal/Reconsideration <input type="radio"/>		CPT CODE(S):	
PEER-TO-PEER CONTACT NAME <i>If other than requestor:</i>		PHONE / HOURS:	

Please include all supporting clinical documentation to validate this request.

Revised 04.17.17 | IMO Plano Office | Confidential