



Pre-Authorization Request Form

DATE: _____

PROVIDER INFORMATION

Servicing Provider

Name: _____

NPI #: _____

Provider #: _____

Address: _____

Phone: (____) _____

Fax: (____) _____

Contact Name/Phone #: _____

Facility/Home Health Agency Name: _____

Ordering Provider

Name: _____

NPI#: _____

Provider#: _____

Address: _____

Phone: (____) _____

Fax: (____) _____

Contact Name/Phone #: _____

Facility/Home Health Agency ID: _____

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Group #: _____

Address: _____

Subscriber Name: _____

Member ID #: _____

Phone (____) _____

Specific Procedure Planned: _____

Diagnosis Code(s): _____

Procedure (CPT) Code(s): _____

Service Dates: ____/____/____ to ____/____/____

*****Please attach relevant medical documentation*****

*****For prompt processing of your request- please complete ALL fields*****

Pre-Authorization Request Form

Fax form to: (651)662-2810

Mail form to: Integrated Health Management, PO Box 64668, St Paul
Minnesota 55164-0668