INNOVATION CARE PARTNERS
AFFILIATED WITH HONORHEALTH

Prior Authorization Form

FAX: 480-588-8061

Incomplete forms will be faxed back to sender:

Instructions:

- **Please validate patient eligibility and benefits prior to rendering services**
- **FAX completed forms to (480)588-8061 or 1-833-665-1252**
- **Submit all clinical documentation such as progress notes/labs/radiology with requests**
- **For questions please contact the Medical Management Department at (800) 250-6647 or (480) 400-0027**

Eligibility Verified
Yes No

Payment for services is dependent upon the patient's eligibility at the time services are rendered. Copays, coinsurance and/or deductibles may apply. Pre-certifications are valid for the date range specified on this form.

This authorization request is approved based on Medical Necessity only and is not a guarantee of payment

Member Name	DOB	(Health Plan) ID Number
Member Address (Street, City, Zip Code)		Member Phone Number
Member E Mail:		Member Alt Number
Requesting Provider	Practice Phone Number	Practice Fax Number
Requesting Provider NPI:	Requesting Provider Tax ID:	Date Sent

☐ Inpatient ☐ Outpatient	Prepared by	Requesting Provider Address:

☐ Routine/Standard Request:	Decisions will be rendered within **15 calendar days** from receipt of all necessary information
☐ Urgent Request:	Decisions will be rendered within **72 hours** from receipt of all necessary information. A request is urgent if the routine/standard turn-around-time could seriously jeopardize the life, health or ability to regain maximum function or subject the member to sever pain that cannot be managed without requested treatment

Facility / Provider Name	Phone Number
Facility / Provider Address (Street, City, Zip Code)	Fax Number
Facility/ Provider E Mail:	

Tax ID	NPI	Expected Date-of-Service	Inpatient Length of Stay

Diagnosis	ICD-10 Code	Procedure or Equipment	Procedure Code	Units

Reason for request (Please submit all pertinent documentation with request)

For ICP UM use only

Pre-Certification Number	Date Range	Initials	☐ Approved ☐ Denied

☐ Retro-Approval (Services rendered without a Pre-Certification) ☐ Approved Units:

Comments:

HIPAA Notice: The information contained in this form may contain confidential and legally privileged information. It is only for the use of the individual or entity named above. If the recipient of this form is not the recipient addressed on the form, you are hereby notified that any dissemination, distribution or copying of the attached document(s) is strictly prohibited. If you have received this in error, please immediately notify the sender by telephone and return the form to the sender.

Org.11/17/ Rev.