INNOVATION CARE PARTNERS PRIOR AUTHORIZATION FORM

FAX: 480-588-8061



Inpatient Concurrent (currently admitted to an inpatient facility)

Incomplete forms will be faxed back to sender.

PreService

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Instructions:

REQUEST TYPE:

• Please validate patient eligibility and benefits prior to rendering services

Post Service (Retro)

- FAX completed forms to (480) 588-8061 or (833) 665-1252 OR EMAIL to icppa@icphealth.com
- Submit all supporting clinical information such as progress notes/labs/radiology with requests

For questions, please contact the Medical Management Department at (480) 400-0027 or (800) 250-6647

PRIORITY:	Routine	Urgent		Τ	ODAY'SDATE (n	nm/dd/yyyy):		
INPATIENT CONCURREN	NT(IP/Obs) De	cision will	be rendered within 2	24 hours from rece	ipt of all neces	ssary information.		
URGENT* PRESERVICE	De	cision will	be rendered within	72 hours from rece	eipt of all nece	ssary information.		
PRESERVICE (Routine)	De	cision will	be rendered within	15 calendar days fro	om receipt of a	all necessary information.		
POST SERVICE (Retro)	De	cision will	be rendered within	30 calendar days fro	om receipt of a	all necessary information.		
		[Post Service (Retro) requests are accepted up to 12 months from the date of service.]						
						the life, health or ability to		
regain maximum fur	nction or subj	ect the me	ember to severe pa	ain that cannot be	: managed wit	thout requested treatment.		
☐ Check Box	x if you are rea	questinga	GAP (applies when	ı services are not :	F			
MEMBER INFORMATION:	:					Member ID#		
First Name			Last Name			DOB		
Member Address					Member Telephone Number			
SPECIALIST OR SERVICING PRACTITIONER INFORMATION: Decisions will be faxed back to the Specialist or Servicing Practitioner First Name Last Name			vicing Practitioner fo	גג number provided	1	ohone Number		
Office Address					Office Fax Number			
Tax ID#		Practition	oner NPI#		Practice Name			
□ Please check box i	ifreferring pra	ıctitioneri	sin-network. Referr	ingpractitionersn	ame:			
PLACE OF SERVICE:	INPATIE	.NT	NT OBSERVATION >72 hours		Length of stay			
	OUTPAT	IENT	OFFICE	HOME	OTHER:	:		
DATE (OF SERVICE (I	Jpcoming	or Past):	OR- [] TBD "TO BE	, DETERMINED"		
FACILITY / COMPANY INF	FORMATION:	□Ch	eck Box if p lace of	service is same a	s Specialist c	or Servicing Practitioner		
Facility Name	_				Facility Tele	phone Number		
Facility Address					Facility Fax N	- Number		
Facility Tax ID# Facility NPI#								
HIPAA Notice: The info	ormation contains	ned in this	form may contain con	fidential and legally	J privileged infor ssed on the forr	rmation. It is only for the use of m. you are hereby notified that		

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DDEDADEDC INIC				Member ID#		
PREPARERS INFO	JRMATION:	Direct Telephone Number & E	Extension	Email		
REQUESTED MEDICAL PRO	OCEDURE/SERVICE	/DEVICE:	1	L		
Diagnosis Description	ICD-10 Code(s)	Request/Procedure Description	on	CPT Code(s)	Units	
		-				
Additional comments:						
					_	
		FOR ICP UM USE ONL	V			
Reference Number	Date Range	TOITICE OW OUL ONL	<u>Determina</u>	ation	Approved Units	
			□APPROVED			
		□APPR		VED POSTSERVICE (Retro)		
				AL APPROVAL/DENIAL		
			□DENIAL	<u>-</u>		
<u>Comments:</u>						
<u>An approv</u>	<u>red authorization i</u>	<mark>is based on Medical Necessity o</mark>	only and is	not a guarantee of paym	<u>ent</u>	
		the patient's eligibility at the time pertaining to eligibility, benefit				
processing, please co	ontact AmeriBen at ((602) 231-8855.				

Please note: A current listing of ICP's services requiring Prior Authorization can be found on our website: https://www.icppatient.com/ under the "Tools and Resources" tab.

We want to hear from you! We would love to hear about your experience with us. Please take our brief survey by going to this website: https://www.surveymonkey.com/r/MedManagementSurvey

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INNOVATION CARE PARTNERS MEDICAL MANAGEMENT DEPARTMENT



Innovation Care Partners Satisfaction Survey

Please take a moment to complete our brief survey. Email completed survey to icppa@icphealth.com or fax to 480-588-8061.

1.	How would you rate your overall experience? (5 being the highest rating)							
	1	2	3	4	5			
2.	If you had Yes	d a question c No	or issue, was it res Not Applicable	olved?				
3.	Is there a experience		ould have done di	fferently to	o provide you with a	better		
	If "Yes", p	olease explair) <i>:</i>					
4.	If a repres	sentative assi	sted you, how wo	ould you ra	te their professional	ism?		
	1	2	3	4	5			
	Would you like to provide recognition or comments regarding our staff:							
5.	Would yo	ou like a team No	member to follow	v up with y	/ou?			
	If "Yes", what is your name & telephone number?							