INNOVATION CARE PARTNERS
PRIOR AUTHORIZATION FORM
FAX: 480-588-8061

INNOVATION CARE PARTNERS
AFFILIATED WITH HONORHEALTH

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 (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

REQUEST TYPE: ☐ PreService ☐ Post Service (Retro) ☐ Inpatient Concurrent (currently admitted to an inpatient facility)

PRIORITY: ☐ Routine ☐ Urgent

TODAY'S DATE (mm/dd/yyyy):_____

INPATIENT CONCURRENT (IP/Obs)	Decision will be rendered within 24 hours from receipt of all necessary information.
URGENT* PRESERVICE	Decision will be rendered within 72 hours from receipt of all necessary information.
PRESERVICE (Routine)	Decision will be rendered within 15 calendar days from receipt of all necessary information.
POST SERVICE (Retro)	Decision will be rendered within 30 calendar days from receipt of all necessary information. *[Post Service (Retro) requests are accepted up to 12 months from the date of service.]*

*Urgent requests apply when: The preservice (routine) time frame could seriously jeopardize the life, health or ability to regain maximum function or subject the member to severe pain that cannot be managed without requested treatment.

☐ Check Box if you are requesting a GAP (applies when services are not available in-network)

MEMBER INFORMATION:

First Name	Last Name	DOB	Member ID#

Member Address	Member Telephone Number

SPECIALIST OR SERVICING PRACTITIONER INFORMATION:
Decisions will be faxed back to the Specialist or Servicing Practitioner fax number provided.

First Name	Last Name	Office Telephone Number

Office Address	Office Fax Number

Tax ID#	Practitioner NPI#	Practice Name

☐ Please check box if referring practitioner is in-network. Referring practitioners name: _____

PLACE OF SERVICE: ☐ INPATIENT ☐ OBSERVATION >72 hours Length of stay_____
☐ OUTPATIENT ☐ OFFICE ☐ HOME ☐ OTHER:_____

DATE OF SERVICE (Upcoming or Past): _____ -OR- ☐ TBD "TO BE DETERMINED"

FACILITY / COMPANY INFORMATION: ☐ Check Box if **place of service is same as Specialist or Servicing Practitioner**

Facility Name	Facility Telephone Number

Facility Address	Facility Fax Number

Facility Tax ID#	Facility NPI#

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Member ID#

PREPARERS INFORMATION:

Name	Direct Telephone Number & Extension	Email

REQUESTED MEDICAL PROCEDURE/SERVICE/DEVICE:

Diagnosis Description	ICD-10 Code(s)	Request/Procedure Description	CPT Code(s)	Units

Additional comments:

FOR ICP UM USE ONLY

Reference Number	Date Range	Determination	Approved Units
		☐APPROVED ☐APPROVED POSTSERVICE (Retro) ☐PARTIAL APPROVAL/DENIAL ☐DENIAL	

Comments:

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

Payment for services is dependent upon the patient's eligibility at the time services are rendered. Copays, coinsurance and/or deductibles may apply. For information pertaining to eligibility, benefits (deductible, coinsurance, copayments) or claims processing, please contact 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