Request for Precertification

Fax to: (806) 373-1458 or

Email to Precert.Fax@imsm.net

IMS Managed Care
Imstpa.com | PO Box 15688 | Amarillo TX 79105

Precertification is the determination of Medical Necessity as defined by the respective Health Plan.
Please **submit Medical Records** along with your **completed Precertification Request** so as to expedite the determination process.
You should have determined that PreCert is required by contacting our support staff at 806-373-6666 or 1-800-687-3020.

Today's Date: _____ Faxed By: _____Call Ref#: _____

Phone & Ext (REQUIRED) _____ Fax: _____

Patient Name: _____

DOB: _____ Patient Phone: _____

Insured Name: _____ SS# of Insured: _____

Employer: _____ Mbr ID# (from Card): **Required**_____

Diagnosis: (both the description and the ICD 10 is required):

1. _____ ICD-10: _____

2. _____ ICD-10: _____

Treatment/Procedure (both the description and CPT Code is required:

1. _____ CPT: _____

2. _____ CPT: _____

Requesting Physician: _____

Phone: _____ Fax: _____ Tax ID: _____

Specialty: _____ City/State: _____ Zip: _____

Facility Name: _____ Phone: _____

Tax ID: _____ UR Dept. Phone: _____ UR Dept. Fax: _____

City/State: _____ Zip (Required) : _____

Surgery/Admit Date: _____ Inpatient or Outpatient (please circle one)