Request for Precertification/ Predetermination for Chemotherapy/Radiation

Fax to: (806) 373-1458 or Email to: Precert.Fax@imsm.net

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

Please Complete with all *Required Items

Precertification is the **determination of Medical Necessity as defined by the respective Health Plan**. Please **submit Medical Records** along with TREATEMENT ORDERS, ALONG WITH your **completed Precertification Request** so as to expedite the determination process. **You should have determined whether Precertification or Predetermination 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* _____ Fax* _____

Patient Name: _____

DOB: _____ Patient Phone: _____

Insured Name: _____ SS# of Insured: _____

Employer: _____ Member ID# *: _____

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

1. _____ ICD-10: _____

2. _____ ICD-10: _____

Treatment/Procedure (Description & CPT Code is required) & the # of Units/Cycles/doses:

1. _____ CPT: _____ # of Units/Cycles/doses: _____

2. _____ CPT: _____ # of Units/Cycles/doses: _____

3. _____ CPT: _____ # of Units/Cycles/doses: _____

Requesting Physician: _____

Phone: _____ Fax: _____ Tax ID: _____

Specialty: _____ City/State: _____ Zip: _____

Facility Name: _____

Phone: _____ UR Dept. Phone: _____ UR Dept. Fax: _____

Tax ID: _____ City/State: _____ Zip*: _____

PLEASE INCLUDE THE ***TREATMENT ORDERS*** WITH UNITS/CYCLES/DOSES OUTLINED.