INDUSTRIAL COMMISSION OF ARIZONA

MEDICAL TREATMENT PREAUTHORIZATION FORM

*Instructions for using this form are available HERE

SECTION I – PROVIDER REQUEST FOR PREAUTHORIZATION (PROVIDER TO COMPLETE/SUBMIT TO PAYER)

PATIENT/EMPLOYEE INFORMATION

Name (Last, First, Middle):	
Date of Injury (MM/DD/YYYY):	Date of Birth (MM/DD/YYYY):
Payer Claim No.	Social Security Number:*1

PROVIDER INFORMATION

Name:	Contact Name:
Phone:	Specialty:
Preferred Method of Contact: ☐ E-mail ☐ Fax	E-mail **or** Fax:

PAYER INFORMATION
(Self-Insured Employer, Insurance Carrier, Third-Party Administrator, or Special Fund)

Name:	Contact Name:

Diagnosis/ICD Code	Treatment/Services Requested ☐ Urgent ☐ Routine	CPT/NDC Code

☐ I have attached documentation to support the medical necessity and appropriateness of the treatment/services requested.

Original sent to **Payer** via: ☐ U.S. Mail ☐ E-mail ☐ Fax	Requested Treatment/Services Supported by ODG? ☐ Yes ☐ No ☐ Unknown
Payer Mailing Address, Fax, **or** Email:	
Provider Signature:	Date Sent:

SECTION II – PAYER DECISION ON REQUEST FOR PREAUTHORIZATION (Payer Decision supported by IME? ☐ Yes ☐ No)

Preferred Method of Contact: ☐ E-mail ☐ Fax	E-mail **or** Fax:
Date Req. for Preauthorization Received:	ICA Claim No.:
Payer Response: ☐ Approved ☐ Partially Denied ☐ Denied ☐ Request for Preauthorization Incomplete ☐ IME Requested	
☐ I have attached a statement of the approved treatment/services or, if not approved, the reasons supporting a denial/partial denial.	
☐ Original sent to **Provider** via Provider's Preferred Method of Contact (*see* above).	Copy to: ☐ Employee ☐ Employee's Attorney
Payer Signature:	Date Sent:

SECTION III – PROVIDER OR EMPLOYEE REQUEST FOR RECONSIDERATION OF PAYER DECISION

☐ I have attached a statement of the reasons and justifications supporting the Request for Reconsideration.

☐ I have attached documentation to support the medical necessity and appropriateness of the treatment/services requested.

☐ Original sent to **Payer** via Payer's Preferred Method of Contact (*see* Section II above).

Provider or Employee Signature:	Date Sent:

SECTION IV – PAYER DECISION ON REQUEST FOR RECONSIDERATION (Payer Decision supported by IME? Yes ☐ No ☐)

Payer Response: ☐ Approved ☐ Partially Denied ☐ Denied ☐ IME Requested	Date Req. for Reconsideration Received:

☐ I have attached a statement of the approved treatment/services or, if not approved, the reasons supporting a denial/partial denial.

☐ Original sent to **Provider** via Provider's Preferred Method of Contact (*see* above).	Copy to: ☐ Employee ☐ Employee's Attorney
Payer Signature:	Date Sent:

SECTION V – PROVIDER OR EMPLOYEE REQUEST FOR ADMINISTRATIVE PEER REVIEW **(SUBMIT TO ICA)**

Reason for Request for Administrative Review:
☐ Payer Non-Response ☐ Denial/Partial Denial of Requested Treatment/Services

☐ I have attached copies of all relevant medical records and (if applicable) documentation related to Payer's non-response.

☐ I have attached copies of all documentation and statements previously attached to Sections I-IV (above).

Original sent to **ICA MRO** via:
☐ U.S. Mail (800 W. Washington St., Phoenix, AZ 85007) ☐ E-mail (MRO@azica.gov) ☐ Fax (602-542-4797)

Provider or Employee Signature:	Date Sent:

***1 Disclosure of a Social Security Number is voluntary. This information may be used to establish positive identification of the patient's workers' compensation claim. ICA-MRO-1.1**