Independent Clinics
OF WASHINGTON

Pre-Authorization Request

ICW prior authorization: 206-878-1985 opt 4 Fax: 206-834-6000
To prevent delay in processing your request, please fill out form in its entirety with all applicable information.

Today's date:

Member Information

First name: Last name: DOB:

Member Plan: UHC Apple Health UHC Medicare HMO UHC Medicare PPO Wellpoint

Member ID: Member Contact Phone:

Referring Provider Information

Full name:

NPI: Tax ID number (TIN):

Office contact name: Office phone: Office fax:

Address: City, State ZIP code:

Specialty:

Servicing Provider Information

Full name:

NPI: TIN:

Office contact name: Office phone: Office fax:

Address: City, State ZIP code:

Specialty:

Facility Information

Name:

NPI: TIN:

Facility contact name: Facility phone: Facility fax:

Address: City, State ZIP code:

Requested Service

Date/date range of service:

ICD-10 code(s):

CPT code(s) (include requested units):

Place of service: ☐InpatientHospital ☐Outpatient Hospital ☐Ambulatory surgery center ☐Office ☐Home ☐ Nursing Facility ☐Other (Please Specify):

Please submit all appropriate clinical information, provider contact information and any other required documents with this form to support your request.

Priority Status: ☐Standard (1-5 days*) ☐Appointment Scheduled (Standard with triage) ☐Urgent/Emergent (Potential for loss of life or limb. 24hrs)

***ICW follows turnaround times of a maximum of 5 days for Medicaid programs and 7 days for Medicare programs
Disclaimer: Authorization is based on verification of member eligibility and benefit coverage at the time of service and is subject to ICW's Authorization Guidelines and claims payment policy and procedures.