

MEDICAL SERVICE Prior Authorization Form

FAX: 1-877-358-8793

www.HealthChoiceUtah.com



Providers are required to send medical documentation supporting the requested service.

Member Name (Last, First)	Member ID#	DOB	Date of Request
Requesting Provider Name		NPI#	
Office Contact Person	Direct Phone #	Fax #	
Diagnosis 1 (ICD-10 code)	Diagnosis 2 (ICD-10 code)	Diagnosis 3 (ICD-10 code)	

<ul style="list-style-type: none"> • Standard (up to 14 calendar days).....No Signature Required. • Expedited (up to 3 business days).....By signing below, you are requesting expedited processing. Therefore, you are certifying that applying the standard review time frame may seriously jeopardize the member's life, health or ability to regain maximum function. 	
Provider Signature	Date

<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	Specialist Name (Last, First)	Specialty		
Name of Facility (if applicable)			Date of service	
Address	NPI#	Phone #		
Name of Procedure	CPT code 1	CPT code 2	CPT code 3	CPT code 4
<input type="checkbox"/> Physical Therapy ___ # of visits/units	<input type="checkbox"/> Occupational Therapy ___ # of visits/units	<input type="checkbox"/> Speech Therapy ___ # of visits/units	<input type="checkbox"/> Home Health ___ # of visits/units	
Contracted Ancillary Service Request (DME; O&P; Equipment) and HCPCS Code (or attach list of codes)				

Medication Request for Administration for Physician Office Administration

Name of Medication (and J-code)	Dosage	Quantity/Amount	Refills (<12)
Sig/Instructions		Allergies	
List Medications Tried/When			
List Medications Contraindicated/Reason			
Provider Signature			Date