

# MEDICAL SERVICE Prior Authorization Form

FAX: 1-877-358-8793

www.HealthChoiceUtah.com



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

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

- **STANDARD** (up to 14 calendar days).....No Signature Required.
- **EXPEDITED** (up to 3 business days).....**By signing below, you are requesting expedited processing and that the request fits into one of the two categories below.**
  - **Processing within the standard timeframe will jeopardize the life or health of the member and impact ability to regain maximum function.**
  - **Processing within the standard timeframe will cause a barrier to transition of care****Therefore, you are certifying, as the ordering provider, that applying the standard review time frame may seriously jeopardize the member's life, health or ability to regain maximum function.**

Ordering Provider Signature

Date

<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<input type="checkbox"/> ASC <input type="checkbox"/> Office	Specialist Name (Last, First)	Specialty	
Name of Facility (if applicable)		Date of service		
Address	NPI#	TIN#	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	<input type="checkbox"/> Office _____ # of visits
Contracted Ancillary Service Request (DME; O&P; Equipment) and HCPCS Code (or attach list of codes and costs)				

## 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		