Health Plan

Exclusive

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PRE-AUTHORIZATION REQUEST FORM

Date Requested:_____

Routine _____
Urgent (1-2 Days to DOS) _____

PATIENT INFORMATION:

Name and DOB:
Address:
Phone:
UCH/Children's MRN:

INSURANCE INFORMATION:

Policy ID#
Insured Name:
Relationship to Patient
Primary Care Physician:
Office Location:
Phone Number:

PROVIDER & FACILITY INFORMATION:

Requesting Provider Name NPI/Tax ID:
Facility Name NPI/Tax ID numbers:
Contact Name/Phone and Fax:

PROCEDURE:

Procedure and CPT Code(s):
Diagnosis and ICD- Code(s):
Outpatient DOS:
Inpatient admit DOS/LOS (**Required for all IP stay)**:

Reason for Extended LOS:
_____

D/C Date: _____ D/C to _____ *Office Use Only*

APPROVED: _____ Date: _____

Signature_____
_____
Printed Name of Reviewer
Reason for Denial:
☐ Medical Necessity not established
☐ Non-covered benefit
☐ Other (list):_____

Provider Verbal Notification:
Date:_____
Person Notified_____

DENIED: _____ Date: _____

Signature_____
_____
Printed Name of Reviewer
Reason for Denial:
☐ Medical Necessity not established
☐ Non-covered benefit
☐ Other (list):_____

Provider Verbal Notification:
Date:_____
Person Notified_____

PENDED: _____ Date: _____

Signature_____
_____
Printed Name of Reviewer
Reason for Pend:
For: Addl Med Records_____
Other_____
Date Info Rcvd:_____

Provider Verbal Notification:
Date:_____
Person Notified_____
_____