PEHP Health & Benefits

PRIOR AUTHORIZATION for MEDICAL / SURGICAL SERVICES

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Customer Service at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

Date Requested:	Name (Last, First MI):	DOB:	Age:	PEHP ID #:

Section II: PROVIDER INFORMATION

***Ordering* Provider:**	**Provider NPI #:**	**Provider Tax ID #:**	**Provider Address:**
***Ordering* Provider Contact Person:**	**Contact Person Phone:** ( )	**Contact Person Facsimile:** ( )	**Contact Person Email:**
***Rendering* Provider:**	**Provider NPI #:**	**Provider Tax ID #:**	**Provider Address:**
***Rendering* Provider Contact Person:**	**Contact Person Phone:** ( )	**Contact Person Facsimile:** ( )	**Contact Person Email:**
***Facility/Hospital*:**	**Facility NPI #:**	**Facility Tax ID #:**	**Facility Address:**
***Facility/Hospital* Contact Person:**	**Contact Person Phone:** ( )	**Contact Person Facsimile:** ( )	**Contact Person Email:**

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.*

☐ Auth Extension ☐ Pre-Auth ☐ Retro Auth ☐ Urgent

Requested Date of Service:

From: **To:**

Place of Service: *Please check.*

☐ Ambulatory Surgical Center ☐ Inpatient ☐ Office ☐ Outpatient

Type of Service (s) being requested: *Please check.*

☐ Inpatient Surgery ☐ Outpatient Surgery ☐ Diagnostic ☐ Medical ☐ Other (*please specify*) ______________________________

Primary Diagnosis/ICD-10 Code:

Secondary Diagnosis/ICD-10 Code:

Are services related to a motor vehicle accident? ☐ Yes ☐ No

Date of Accident: ______________________________

Are services related to a work-related injury? ☐ Yes ☐ No

Date of Injury: ______________________________

Durable Medical Equipment (DME) Requested: *Please list all requested services regardless of pre-authorization requirement. Unlisted codes cannot be pre-authorized.*

DME Description: ______________________________ HCPCS: ______________
Please check all that apply: ☐ Bilateral Sides ☐ Duplicate ☐ Left Side ☐ Right Side ☐ Purchase ☐ Rental ☐ Repair ☐ Replacement ☐ Upgrade

DME Description: ______________________________ HCPCS: ______________
Please check all that apply: ☐ Bilateral Sides ☐ Duplicate ☐ Left Side ☐ Right Side ☐ Purchase ☐ Rental ☐ Repair ☐ Replacement ☐ Upgrade

DME Description: ______________________________ HCPCS: ______________
Please check all that apply: ☐ Bilateral Sides ☐ Duplicate ☐ Left Side ☐ Right Side ☐ Purchase ☐ Rental ☐ Repair ☐ Replacement ☐ Upgrade

Inpatient Services: ***For Inpatient Rehabilitation or Skilled Nursing Facility admissions or extensions please use PEHP's "Inpatient Rehabilitation and Skilled Nursing Facility" pre-authorization form.*

Anticipated Admission Date: ______________ **Estimated Length of Stay:** ______________

Service (s) Requested: *Please list all requested services regardless of pre-authorization requirement. Unlisted codes cannot be pre-authorized.*

Service Description: ______________________________ CPT/HCPCS: ______________ ☐ Bilateral ☐ Left ☐ Right

Service Description: ______________________________ CPT/HCPCS: ______________ ☐ Bilateral ☐ Left ☐ Right

Service Description: ______________________________ CPT/HCPCS: ______________ ☐ Bilateral ☐ Left ☐ Right

Service Description: ______________________________ CPT/HCPCS: ______________ ☐ Bilateral ☐ Left ☐ Right

Product Name: ______________ Application CPT: ______________ Product HCPCS: ______________ Number of Units Required: ______________

Product Name: ______________ Application CPT: ______________ Product HCPCS: ______________ Number of Units Required: ______________

Additional Comments:

By submitting this form, I attest that the information provided is true and accurate to the best of my knowledge.

****Please fax completed form and medical records to 801-366-7449.***