PRIOR AUTHORIZATION for AMBULATORY and VIDEO ELECTROENCEPHALOGRAPHY

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 Member & Provider Services 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(S) INFORMATION

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

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.* ☐ Auth Extension ☐ Pre-Auth ☐ Retrospective Auth ☐ Urgent	**Requested Date(s) of Service:** **From:** **To:**	**Place of Service:** *Please check.* ☐ EEG Lab ☐ Home ☐ Inpatient ☐ Office ☐ Outpatient
Primary Diagnosis/ICD-10 Code:	**Secondary Diagnosis/ICD-10 Code:**	**A. Does the patient live alone?** ☐ Yes ☐ No
B. Type of EEG Requested: ☐ Ambulatory ☐ Ambulatory-Video ☐ Video	**C. Duration of Study:**	**D. Will monitoring be attended by technologist?** ☐ Yes ☐ No

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

Procedure/Service: _____ CPT code(s): _____

Procedure/Service: _____ CPT code(s): _____

Procedure/Service: _____ CPT code(s): _____

(Please check study being requested.) **QUESTION**	**YES**	**NO**	**COMMENTS/NOTES**
F. ☐ Ambulatory Electroencephalographic (A-EEG) Monitoring (Home):			
1. Has the patient had a neurological examination, and a standard EEG performed within the past 12 months?	☐	☐	***Please submit routine EEG.***
2. Does the patient have an established diagnosis of epilepsy, and an A-EEG is being requested to classify the seizure type to select or adjust anti-epileptic drug (AED) therapy because a routine EEG was non-diagnostic?	☐	☐	
3. Does the patient have intractable epilepsy, and an A-EEG is being requested to determine characterization (lateralization, localization, distribution) of EEG abnormalities, both ictal (i.e., seizure, stroke, headache) and interictal (period between seizures) for surgical evaluation?	☐	☐	
4. Is the test being requested to establish a diagnosis of a seizure disorder because the patient has episodes suggestive of epilepsy, but history, examination, and routine EEG did not resolve the diagnostic uncertainties (routine EEG should be negative with provocative measures)?	☐	☐	
G. ☐ Combined Ambulatory Video Electroencephalographic (AV-EEG) Monitoring (Home/EEG Lab):			
1. Has the patient had a neurological examination, and a standard EEG performed within the past 12 months?	☐	☐	***Please submit routine EEG.***
2. Is AV-EEG being requested because seizure activity is captured on routine EEG but does not yield sufficient qualitative or quantitative data to determine a treatment regimen?	☐	☐	
3. Is AV-EEG being requested because seizure activity is observed clinically but not captured by routine EEG?	☐	☐	
4. Is AV-EEG being requested to differentiate epileptic events from psychogenic seizures?	☐	☐	
H. ☐ Video Electroencephalographic (V-EEG) Monitoring (Inpatient):			
1. Is inpatient V-EEG being requested because a diagnosis of a seizure disorder cannot be made by neurological examination, standard EEG studies, and ambulatory EEG monitoring performed within the past 12 months? and non-neurological causes of symptoms (i.e., syncope, cardiac arrhythmias) have been ruled out?	☐	☐	***Please submit all reports for applicable diagnostic studies done.***
2. Have non-neurological causes (e.g., cardiac arrhythmias, extreme stress, panic attacks, substance withdrawal, severe pain, syncope) of the patient's symptoms been ruled out?	☐	☐	
3. Is inpatient V-EEG being requested to document provocation of seizures after anti-epileptic drug (AED) withdrawal for the purpose of making medication adjustments or determine an appropriate treatment plan?	☐	☐	
4. Is inpatient V-EEG being requested to establish the specific type of epilepsy in poorly characterized seizure types because characterization is medically necessary to select the most appropriate therapeutic regimen?	☐	☐	
5. Is inpatient V-EEG being requested to monitor seizures of a neonate or child so a treatment regimen can be developed?	☐	☐	

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.