# 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 Customer Service at (801) 366-7555 or toll free at (800) 753-7490.**

## Section I: PATIENT INFORMATION

| Name (Last, First MI): | DOB: | Age: | PEHP ID #: |
|---|---|---|---|
| | | | |

## Section II: PROVIDER INFORMATION

| Date Requested: | Service Provider Name: |
|---|---|
| Service Provider NPI #: / Service Provider Tax ID #: | Service Provider Address: |

| Contact Person: | Phone: ( ) | Facsimile: ( ) |
|---|---|---|

## Section III: PRE-AUTHORIZATION REQUEST

**Nature of Request:** *Please check.*
☐ Auth Extension ☐ Pre-Auth ☐ Retrospective Auth ☐ Urgent

**Requested Date (s) of Service:**

**Place of Service:** *Please check.*
☐ Home ☐ Inpatient ☐ Office ☐ Outpatient

**Will monitoring be attended by a technologist?** ☐ Yes ☐ No

**Will monitoring be a combined ambulatory video EEG study?** ☐ Yes ☐ No

| **Facility Name:** | **Facility NPI #:** | **Facility Tax ID #:** |
|---|---|---|
| **Facility Address:** | **Facility Phone:** ( ) | **Facility Facsimile:** ( ) |

| **Primary Diagnosis/ICD-10 Code:** | **Secondary Diagnosis/ICD-10 Code:** |
|---|---|
| | |

**Service (s) Requested**: *Please list all requested services/CPT codes regardless of pre-authorization requirement.*

Procedure/Service: ______________________________ CPT/HCPCS code: ____________________
Procedure/Service: ______________________________ CPT/HCPCS code: ____________________
Procedure/Service: ______________________________ CPT/HCPCS code: ____________________

| *(Please check service being requested.)* **QUESTION** | **YES** | **NO** | **COMMENTS/NOTES** |
|---|---|---|---|
| **A.** ☐ **Ambulatory Electroencephalographic (EEG) Monitoring (Home):** | | | *Please submit routine EEG report.* |
| 1. Does the patient have a seizure disorder with an equivocal or ambiguous EEG and the test is being requested to classify type of seizure to facilitate selection of appropriate anti-epileptic drug therapy? | ☐ | ☐ | |
| 2. 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)? | ☐ | ☐ | |
| 3. Is the test being requested for localization of epileptogenic region of the brain during pre-surgical evaluation to determine if the patient is an appropriate surgical candidate? | ☐ | ☐ | |
| **B.** ☐ **Combined Ambulatory Video Electroencephalographic (AV-EEG) Monitoring (Home/EEG Lab):** | | | *Please submit routine EEG report.* |
| 1. Is the seizure activity observed clinically but not captured by routine EEG? | ☐ | ☐ | |
| 2. Is the seizure activity captured on routine EEG but does not yield sufficient qualitative or quantitative data to determine a treatment regimen? | ☐ | ☐ | |
| 3. Is the test being requested to differentiate epileptic events from psychogenic seizures? | ☐ | ☐ | |
| **C.** ☐ **Video Electroencephalographic (V-EEG) Monitoring (Inpatient):** | | | *Please submit all reports for applicable diagnostic studies done.* |
| 1. Is the test being requested because a diagnosis of epilepsy cannot be made by neurological examination, standard EEG studies, ambulatory EEG monitoring and non-neurological causes of symptoms (i.e. syncope, cardiac arrhythmias) have been ruled out? | ☐ | ☐ | |
| 2. Does the patient have a poorly characterized seizure type and testing is being requested to establish the specific type of epilepsy so appropriate therapeutic regimen can be selected? | ☐ | ☐ | |
| 3. Is the patient a neonate/child and needs seizure monitoring to develop or modify treatment? | ☐ | ☐ | |
| 4. Does the patient have intractable epilepsy and is being evaluated for surgical intervention? | ☐ | ☐ | |
| 5. Is test being requested because antiepileptic drug (AED) withdrawal necessary? | ☐ | ☐ | |

**Additional Comments:**

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