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:	Ordering Provider/Physician:	Ordering Provider/Physician NPI #:	Ordering Provider/Physician Tax ID #:

Ordering Provider/Physician Contact Person:	Ordering Provider/Physician Phone: ( )	Ordering Provider/Physician Facsimile: ( )

Rendering Provider/Facility:	Rendering Provider/Facility NPI #:	Rendering Provider/Facility Tax ID #:	Rendering Provider/Facility Address:

Rendering Provider/Facility Contact Person:	Rendering Provider/Facility Phone: ( )	Rendering Provider/Facility Facsimile: ( )

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.*	Requested Date (s) of Service:	Place of Service: *Please check.*
☐ Auth Extension ☐ Pre-Auth ☐ Retrospective Auth ☐ Urgent		☐ Home ☐ Inpatient ☐ Office ☐ Outpatient

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

Type of EEG Requested: *Please check.*	Anticipated Duration of Study:	Will monitoring be attended by technologist?	Does the patient live alone?
☐ Ambulatory ☐ Ambulatory-Video ☐ Video		☐ Yes ☐ No	☐ Yes ☐ No

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

Procedure/Service: _____ CPT/HCPCS code: _____

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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.