# PRIOR AUTHORIZATION FOR AUTISM TREATMENT BENEFITS

**For authorization, please submit this form with relevant medical records to document diagnosis and mail or FAX to PEHP Prior Authorization Department.**

**Mail:** PEHP Prior Authorization Department
560 East 200 South
Salt Lake City, UT 84102

**FAX:** **1-801-366-7449**

**For questions regarding authorization of Autism Treatment benefits, call PEHP Customer Service:**
**801-366-7555 or toll-free 1-800-765-7347**

| Subscriber name (parent): | Member ID: | | |
|---|---|---|---|
| | | | |
| Address: | Contact information: | | |
| | Day: | Mobile: | Evening: |
| City, State, Zip: | Email address: | | |
| Child's Name: | Child's birth date: | | |
| | | | |
| Primary care physician name: | Physician's address: | | |
| | | | |
| Physician Specialty (i.e., family practice, pediatrics, etc.): | | | |
| | | | |
| Diagnosis (please check one): | | | |
| Autism Disorder ☐ | Asperger Syndrome ☐ | Other or unspecified pervasive developmental disorder ☐ | |
| Diagnosed by: | Date of diagnosis: | | |
| | | | |
| Current provider of behavioral therapy (if applicable): | Address: | | |
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