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

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 / Authorization Period:

Type of Service (s) being requested: *Please check.*
☐ Inpatient Surgery ☐ Outpatient Surgery ☐ Diagnostic ☐ Medical ☐ Other (*please specify*) ______________________

Place of Service: *Please check.*
☐ Ambulatory Surgical Center ☐ Inpatient ☐ Office ☐ Outpatient ☐ Other (*please specify*) ______________________

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

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/codes regardless of pre-authorization requirement.*

DME Description: ______________________ HCPCS code: ______________
Please check all that apply: ☐ Bilateral (Both) Sides ☐ Left Side ☐ Right Side ☐ Purchase ☐ Rental ☐ Replacement ☐ Upgrade

DME Description: ______________________ HCPCS code: ______________
Please check all that apply: ☐ Bilateral (Both) Sides ☐ Left Side ☐ Right Side ☐ Purchase ☐ Rental ☐ Replacement ☐ Upgrade

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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:** ______________

For a complete list of available pre-authorization forms that can be downloaded, please go to https://www.pehp.org/providers/preauthforms.

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

Procedure/Service: ______________________ CPT/HCPCS code: ______________ ☐ Left ☐ Right ☐ Bilateral
Procedure/Service: ______________________ CPT/HCPCS code: ______________ ☐ Left ☐ Right ☐ Bilateral
Procedure/Service: ______________________ CPT/HCPCS code: ______________ ☐ Left ☐ Right ☐ Bilateral
Procedure/Service: ______________________ CPT/HCPCS code: ______________ ☐ Left ☐ Right ☐ Bilateral

Additional Comments:

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