PEHP Health & Benefits

PRIOR AUTHORIZATION for MISCELLANEOUS DIAGNOSTIC TESTING

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.

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

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.*	**Requested Date (s) of Service / Authorization Period:**
☐ Auth Extension ☐ Pre-Auth ☐ Retrospective Auth ☐ Urgent	

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	**Are services related to a work-related injury?** ☐ Yes ☐ No
Date of Accident: _____	*Date of Injury:* _____

A. Type of Diagnostic Test(s) being requested: *Please check.*

1. ☐ Cardiac Computed Tomographic Angiography (Cardiac CTA)
2. ☐ Functional Brain Magnetic Resonance Imaging (fMRI)
3. ☐ Gastrointestinal Function (Colon/Esophageal Motility Study)
4. ☐ Quantitative EEG (Brain Mapping)
5. ☐ Prostate Saturation Biopsy
6. ☐ 3D Diagnostic Mammography (Tomosynthesis/Tomographic)
7. ☐ 3D Screening / Routine Mammography
8. ☐ 3D Screening / Routine Mammography *(Patient is < 40 years old)*
9. ☐ Other (*please specify*) _____

B. Indication for Diagnostic Test(s) being requested: *Please check.*

1. ☐ Annual
2. ☐ Cancer Staging
3. ☐ Diagnostic
4. ☐ Interim Testing for Treatment Response
5. ☐ Personal History of Breast Cancer
6. ☐ Previous "Call-Back" for Repeat Imaging
7. ☐ Prognostic
8. ☐ Screening (Routine)
9. ☐ Surveillance
10. ☐ Other (*please specify*) _____

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

Service: _____ CPT/HCPCS code: _____ ☐ Bilateral ☐ Left ☐ Right

Service: _____ CPT/HCPCS code: _____ ☐ Bilateral ☐ Left ☐ Right

Service: _____ CPT/HCPCS code: _____ ☐ Bilateral ☐ Left ☐ Right

Service: _____ CPT/HCPCS code: _____ ☐ Bilateral ☐ Left ☐ Right

Service: _____ CPT/HCPCS code: _____ ☐ Bilateral ☐ Left ☐ Right

Additional Comments:

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