PRIOR AUTHORIZATION for OUTPATIENT PHYSICAL and OCCUPATIONAL THERAPY

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 Authorization Period/Dates of Service:**
Primary Diagnosis/ICD-10 Code:	**Secondary Diagnosis/ICD-10 Code:**

Service (s) Requested: **Policy year/lifetime limits may apply.*

Service: _____ # of visits approved: _____ # of visits used: _____ # of additional visits requested: _____

Service: _____ # of visits approved: _____ # of visits used: _____ # of additional visits requested: _____

Service: _____ # of visits approved: _____ # of visits used: _____ # of additional visits requested: _____

Section IV: CLINICAL INFORMATION

A. Date of Injury/Surgery: ☐ N/A	**Description of Injury/Surgery:** ☐ N/A	
B. Was the injury work-related? ☐ Yes ☐ No	**Has a Worker's Compensation Claim been filed?** ☐ Yes ☐ No	**Worker's Compensation Claim #:**
C. Was the injury related to a Motor Vehicle Accident (MVA)? ☐ Yes ☐ No	**Date of Accident:**	**Has a personal injury claim been filed?** ☐ Yes ☐ No

For section "D." please document Range of Motion in Degrees, Distance in Feet, Strength 0-5 (0=no movement), and Pain 0-10 (0=no pain).

D. Functional Assessment	**Initial Evaluation Date: _____**	**Current Evaluation Date: _____**
Anatomical Location (joint, side, etc.)		
Extension / Flexion	Extension_____ Flexion _____	Extension _____ Flexion _____
Rotation	Right _____ Left _____	Right _____ Left _____
Lateral Flexion	Right _____ Left _____	Right _____ Left _____
Abduction / Adduction	Abduction _____ Adduction _____	Abduction _____ Adduction _____
Strength (0 - 5)		
Pain (0 – 10) / Location		
Gait / Balance / Transfers		
Barriers / Patient Compliance		

Additional Comments:

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