MEDICAL SERVICE Prior Authorization Form

FAX: 1-877-358-8793

www.HealthChoiceUT.com

Providers are required to send medical documentation supporting the requested service.			
Member Name (Last, First)	Member ID#	DOB	Date of Request
Requesting Provider Name	NPI#	TIN#	
Office Contact Person	Direct Phone #	Fax #	
Diagnosis 1 (ICD-10 code)	Diagnosis 2 (ICD-10 code)	Diagnosis 3 (ICD-10 code)	

- **Standard** (up to 14 calendar days).....No Signature Required.
- **Expedited** (up to 3 business days).....**By signing below, you are requesting expedited processing. Therefore, you are certifying that applying the standard review time frame may seriously jeopardize the member's life, health or ability to regain maximum function.**

Provider Signature	Date

☐ Inpatient ☐ Outpatient	Specialist Name (Last, First)	Specialty
Name of Facility (if applicable)		Date of service
Address	NPI#	Phone #

Name of Procedure	CPT code 1	CPT code 2	CPT code 3	CPT code 4

☐ Physical Therapy ___ # of visits/units ☐ Occupational Therapy ___ # of visits/units ☐ Speech Therapy ___ # of visits/units ☐ Home Health ___ # of visits/units

Contracted Ancillary Service Request (DME; O&P; Equipment) and HCPCS Code (or attach list of codes)

Medication Request for Administration for Physician Office Administration			
Name of Medication (and J-code)	Dosage	Quantity/Amount	Refills (<12)
Sig/Instructions	Allergies		
List Medications Tried/When			
List Medications Contraindicated/Reason			

Provider Signature	Date

Updated on 8/12/2016