MEDICAL SERVICE Prior Authorization Form

FAX: 1-877-358-8793 www.HealthChoiceUtah.com

HEALTH CHOICE UTAH

Medical documentation supporting the requested service MUST be included with this request form.

Member Name (Last, First)	Member ID#	DOB	Date of Request

Ordering 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 72 hours) **By signing below, you are requesting expedited processing and certifying that the request fits into one of these two categories:**

☐ **Processing within the standard timeframe will jeopardize the life or health of the member and impact ability to regain maximum function.**

☐ **Processing within the standard timeframe will cause a barrier to transition of care**

Ordering Provider Signature	Date

☐ Inpatient ☐ Outpatient ☐ ASC ☐ Office	Specialist Name (Last, First)	Specialty

Name of Facility (if applicable)	Date of service

Address	NPI#	TIN#	Phone #

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

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

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

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