DENVER HEALTH MEDICAL PLAN INC.

PRIOR AUTHORIZATION REQUEST FORM

ALL FIELDS MUST BE COMPLETED AND CLINICAL RECORDS INCLUDED WITH THIS FORM IN ORDER TO PROCESS THE REQUEST.

Once completed, fax the form to one of the following numbers:

Inpatient Services (Acute Hospital Admissions, SNF, Rehab, etc.):	303-602-2127
Outpatient Services (Outpatient Procedures, Home Health, Office Visits, Radiology, etc.):	303-602-2128
Durable Medical Equipment:	303-602-2160

REQUEST PRIORITY (choose one): Standard ○ Urgent ○ Concurrent ○ Retrospective ○

Urgent Request: Urgent requests will be downgraded to standard turnaround times if it does not meet at least one of the following criteria. 1) Seriously jeopardize the life or health of the member; 2) for disabled persons, create an imminent and substantial limitation on the ability to live independently; or 3) if the condition subjects the person to uncontrolled pain. Next day appointments do not qualify for Urgent Status. **Concurrent Request:** This is a request to extend treatment beyond the initial approved time period; request must be made 24 hours before the expiration of the authorized time period.
Turn Around Times for Processing a Request: Urgent is 72 hours; Concurrent is 24 hours; Retrospective is 30 days.
Standard: Medicare and CHP+ are 10 days; Medicare is 14 days; Employer Group Plans and Elevate are 15 days.

MEMBER INFORMATION:

Name (Last, First, Middle Initial) | Member DOB (MM/DD/YY)

Member ID # | Member's Primary Care Physician

Member Gender: Male ○ Female ○

ORDERING/REQUESTING PROVIDER INFORMATION:

Provider Name | Contact at Provider Office

Provider NPI # | Provider Phone # | Provider Fax #

INFORMATION OF PROVIDER OR FACILITY WHERE SERVICE WILL BE PERFORMED:

Provider Name | Type of Provider/Specialty | Contact at Servicing Provider

Provider NPI # | Provider Phone # | Provider Fax #

Is provider contracted with Cofinity?: Yes ○ No ○ Is provider contracted with FirstHealth?: Yes ○ No ○

REQUESTED SERVICES (choose one): Inpatient Service ○ Outpatient Service ○

ICD 10 Codes:

All column fields must be completed. DO NOT LEAVE BLANK.

Description of Requested Service	CPT/HCPCS Code	Start Date	End Date	Units