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:

OUTPATIENT FAX: 303-602-2128 INPATIENT FAX: 303-602-2127 URGENT/EXPEDITED FAX: 303-602-2160

REQUEST PRIORITY (choose one): Standard ○ Retrospective ○ Inpatient ○

Medicare Standard Part B Drugs Turn Around Time: 72 hours ○

Medicare Expedited Part B Drugs Turn Around Time: 24 hours ○

○ **FOR URGENT/EXPEDITED REQUESTS, CHECK BELOW TO ATTEST THAT THE MEMBER'S CONDITION MEETS ONE OF THE FOLLOWING.**

Note: Urgent/Expedited requests may be downgraded to standard if it does not meet at least one criteria below.

- ○ Seriously jeopardize the life or health of the member
- ○ Seriously jeopardize the enrollee's ability to attain, maintain or regain maximum function
- ○ Condition subjects the person to uncontrolled pain

Is this prior authorization request for Part B Drug, Medical Injectable, Infusion, J HCPCS code? Yes ○ No ○

MEMBER INFORMATION:

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

Member ID # Member's Primary Care Physician

Member Gender Assigned at Birth: Male ○ Female ○

ORDERING/REQUESTING PROVIDER INFORMATION:

Provider Name Contact at Provider Office Requesting Facility

Provider NPI # Provider Phone # Provider Fax #

SERVICING FACILITY/PROVIDER INFORMATION:

Specialty Clinic Facility Name Provider NPI #

Provider Phone # Provider Fax # Provider Tax ID #

Requested Services: Inpatient Service ○ Outpatient Service ○

DME: Rental ○ Purchase ○

Home Health Start of Care Date (MM/DD/YYYY)

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

DENVER HEALTH MEDICAL PLAN INC.

******** FOR MEDICALLY ADMINISTERED DRUGS ONLY ********

Patient Diagnosis and ICD Diagnostic Code(s):

Drug(s) Requested (with J-Code, if applicable):

Strength/Route/Frequency:

Unit/Volume of Named Drug(s):

New Start: ○ Renewal Request ○

Start Date and Length of Therapy:

Location of Treatment: (e.g. provider office, facility, home health, etc.) including name, Type 2 NPI (if applicable), address and tax ID:

Clinical Criteria for Approval, including other Pertinent Information to Support the Request:

Medications Tried, Their Name(s), Duration, and Patient Response: