DENVER HEALTH MEDICAL PLAN INC.™

PRIOR AUTHORIZATION REQUEST FORM

ALL FIELDS MUST BE COMPLETED AND CLINICAL RECORDS INCLUDED.

Once completed, fax the form to one of the following numbers:
OUTPATIENT FAX: 303-602-2128 INPATIENT FAX: 303-602-2127
URGENT FAX: 303-602-2160

REQUEST PRIORITY (choose one): Standard ☐ Retrospective ☐ Urgent ☐

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

Note: Urgent 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

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 _____ Facility Name _____ Contact Name _____

Phone # _____ Fax # _____ Tax ID # _____ NPI # _____

Requested Services: Inpatient Service ☐ Outpatient Service ☐

DME: Rental ☐ Purchase ☐ Home Health Start of Care Date (MM/DD/YYYY) _____

Diagnosis ICD 10 Codes:

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

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

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

Patient Diagnosis and ICD Diagnostic Code(s):

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

Dosage/Route/Frequency of Drug:

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: