MEDICAL SERVICE Prior Authorization Form

HEALTH | CHOICE
UTAH

FAX: 1-877-358-8793
www.StewardHealthChoiceUT.org

Ordering Providers are required to send medical documentation supporting the requested service.

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 that the request fits into one of the two categories below.**
  - **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 therefore, you are certifying as the ordering provider, that applying the standard review time frame may seriously jeopardize the member's life, health or ability to regain maximum function.**

Ordering Provider Signature (must be signed by the provider, stamp signatures are not acceptable)	Date

☐ Inpatient ☐ ASC ☐ Outpatient ☐ 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