Attn: UM Department-Referral Coordinator — Phone: (206) 326-2453 option 1; Fax: (206) 621-4026

Prior-Authorization Form

	Date:
Patient Name:	DOB:
Insurance ID #:	Patient's PCP:

REFERRAL/SERVICES REQUESTED

Inpatient:	**Outpatient**:	**Other Services**:	☐ Consultation
☐ Surgical procedures	☐ Surgical procedures	☐ Home Health	☐ Office Visit Follow-up
☐ Inpatient Admits	☐ PT, OT & ST	☐ Home Infusion	☐ DME: *Please fax Prior-Auth Form*
☐ Rehab	☐ Imaging ☐ Wound Care	☐ Skilled Services (SN/PT/OT/ST)	*& Rx to* ***206-621-4026***

Service is:	☐ Elective/Routine ☐ Expedited/Urgent*	**__Definition of Expedited/Urgent__: The delay of treatment could jeopardize the life and health of patient, jeopardize patient's ability to regain maximum function or subject patient to severe pain that cannot be adequately managed without the care or treatment requested.*

Behavioral Health:

☐ **__Inpatient__**: *If patient requires inpatient hospital treatment for mental health needs, please send to nearest ED for evaluation*

☐ **__Chemical Dependency__** (CD): *If patient requires CD treatment, they must be assessed by a CD professional to determine appropriate level of care as part of their admission process*

☐ **__Eating Disorder/Residential Treatment__**: *Coordination for these services managed by Behavioral Health Case Manager*

PROCEDURE INFORMATION

ICD-10 Code and Description:	
CPT/HCPCS Code and Description:	
Number of visits requested:	Date of Service:

REFERRED FROM: ORDERING/REFERRING PHYSICIAN INFORMATION

Name:		Contact Name:	
Address:		Specialty Department:	
TIN:	NPI:	Phone:	Fax:

REFERRED TO: REFERRING FACILITY/ PHYSICIAN INFORMATION

Name:		Contact Name:	
Address:		Specialty Department:	
TIN:	NPI:	Phone:	Fax:

SUPPORTING DOCUMENTATION IS REQUIRED! If not received within 48 hrs, referral may be denied for missing information

FOR INTERNAL USE ONLY

Date:	Auth. #:	☐ Approved	☐ Denied
Valid date from:	Valid date to:	Number of visits:	

Notes/Comments:

Processed by ___________________