State of Vermont **Urgent Request**

Uniform Medical Prior Authorization Form **Non-Urgent Request**

**Instructions**: Please complete all fields and submit all additional treatment information and/or medical notes that support your request for benefits. If you need more room, you may attach additional pages or forms. Send or fax this information to the member’s health plan in advance of the proposed services. Please refer to information provided on the health plans’ website for submission instructions and contact information.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Patient/Member Information** (\* Required Field) | | | | | |
| **\*First Name:** **Middle Initial:** **\*Last Name:** | | | | | |
| **\*Health Insurance ID#:** | | **\*DOB** *(MM/DD/YYYY)***:** **/****/** | | | **\*Gender: Male**  **Female**  **Unknown** |
| **\*Address:** **Apt.#:** | | | | | |
| **\*City:** **\*State:** **\*Zip:** **Telephone #:** | | | | | |
| **Referring/Requesting Provider Information** | | | **Rendering/Attending Provider Information** | | |
| **First Name:** **Last Name:** | | | **First Name:** **Last Name:** | | |
| **NPI/TIN #:** **Specialty:** | | | **NPI/TIN #:** **Specialty:** | | |
| **Group/Practice Name:** | | | **Group/Practice Name:** | | |
| **NPI/TIN #:** | | | **NPI/TIN #:** | | |
| **Address:** **Suite #:** | | | **Address:** **Suite #:** | | |
| **City:** **State:** **Zip:** | | | **City:** **State:** **Zip:** | | |
| **Office Contact/**  **Person Completing Form:** | | | | | |
| **Telephone #:** **FAX #:** | | | | | |
| **Required Clinical Information** (\* Required Field) | | | | | |
| **\*Date of Request:** | | | **Is this request for Out-of-Network services?** Yes  No | | |
| **\*Type of Service Requested** | | | | | |
| **Inpatient Care:**  Medical Admit  Mental Health/Substance Abuse Admit  OB  Surgery  Oral Surgery | **Outpatient/Office Care:**  Acupuncture  Chiropractic  Infusion/Oncology Drugs  Mental Health/Substance Abuse | | | **Therapies:**  Occupational Therapy  Physical Therapy  Speech Therapy  Cardiac Rehab | |
| **Testing:**  Diagnostic Imaging  Diagnostic Medical Test | **Other:**  DME  SNF  Home Health Vision/Glasses  Other  - please specify: | | | | |
| **\*Date Diagnosed:** | | | **\*Place of Service:**  Inpatient  Outpatient  Office  Other  - ­specify: | | |
| **\*Proposed Date(s) of Service: From:**  **To:** | | | **\*Facility Where Service Will be Performed:** | | |
| **\*Proposed Number of Inpatient Treatment Days:** | | | **\*Proposed Number of Outpatient Treatment Visits:** | | |
| **\*Primary Diagnosis:** | | | **\*Primary Diagnosis Code:** | | |
| **\*Secondary Diagnosis:** | | | **\*Secondary Diagnosis Code:** | | |
| **\*Name of Proposed Procedure or Test:** | | | **\*CPT/HCPCS or Revenue Code:** | | |
| **\*Requested DME:** | | |  | | |
| **\*DME CPT/HCPCS Code:** | | | **\*Requested DME Duration (Date(s) of Service):** | | |
| **\*DME Purchase Price: $** | | | **\*DME Monthly Rental Price: $** | | |

**Additional Clinical Information Attached:** (No. of pages     )