**VERMONT MEDICAID PRE-PROCEDURE REQUEST FORM**

**Please complete form and provide clinical documentation to support review. Refer to DVHA** [**Criteria**](https://dvha.vermont.gov/forms-manuals/forms/prior-authorizations-tools-and-criteria) **to review requirements for specific procedures. Criteria can be found here:** [**https://dvha.vermont.gov/forms-manuals/forms/prior-authorizations-tools-and-criteria**](https://dvha.vermont.gov/forms-manuals/forms/prior-authorizations-tools-and-criteria)**. Failure to submit all required information will result in a delayed clinical review.**

For out-of-network procedures, see [out-of-network services criteria](https://dvha.vermont.gov/forms-manuals/forms/prior-authorizations-tools-and-criteria/procedure-criteria). For procedures for which DVHA utilizes InterQual criteria, such as bariatric surgery, please refer to the Vermont Medicaid provider [web portal](https://www.vtmedicaid.com/secure/logon.do) to review all information necessary for clinical review.

Date of Request: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Date, if Procedure has been scheduled: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Setting where procedure will be performed:  Hospital Outpatient  Hospital Inpatient

Patient Name: (last) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (first) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Gender:  M  F

Date of Admission: \_\_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Procedure: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Anticipated Discharge Date: \_\_\_\_\_/\_\_\_\_/\_\_\_

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**Provider Information**

Requesting Provider Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** VT Medicaid Provider #: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Requesting Provider NPI #: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Taxonomy #: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Provider Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Contact Person Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Telephone: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Fax: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Facility Information**

Facility Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** VT Medicaid Provider #: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

NPI #: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Taxonomy #: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Facility Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Contact Person Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Telephone: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Fax: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Procedure(s) Requested**

Procedure: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Diagnosis: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

CPT Procedure Code: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ICD-10 Procedure Code: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Procedure: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Diagnosis: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

CPT Procedure Code: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ICD-10 Procedure Code: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Procedure: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Diagnosis: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

CPT Procedure Code: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ICD-10 Procedure Code: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**