Request for Medical Preauthorization

INSTRUCTIONS: Complete the form below, and submit via email (see email addresses at the end of this form) with relevant clinical notes and medical necessity information.

Once SelectHealth® receives this form, we have **14 days** to make a benefit determination unless an expedited review is requested.

This request is (check one): ☐ NON-URGENT ☐ URGENT*

IF you checked "URGENT," please provide the phone number of a person who can immediately discuss the case (not general office number or answering service) **AND** include a written explanation from a medical provider detailing how/why the usual 14 days would:

- Jeopardize the life or health of the member; and/or
- Threaten the member's ability to regain maximum function; and/or
- Subject the member to severe pain and inadequate management of the member's medical condition.

Immediate Contact Ph # (complete ONLY if expedited request) ( )

* **Scheduling issues DO NOT meet criteria for "URGENT."**

Reduce turnaround time for preauthorizations by using CareAffiliate®. Some preauthorization requests even qualify for auto-approval.

To learn more, email **careaffiliate@selecthealth.org**.

Today's Date Dates of Service to

Contact Name Email

Ph # ( ) Fax# ( )

PATIENT INFORMATION

Patient Name Date of Birth

City/State

Primary Health Insurance ID# Plan

Other Health Insurance ID# Plan

PROVIDER INFORMATION

Requesting Provider NPI# Ph# ( )

Street Address City/State

Service Provider _ NPI# Ph# ( )

Street Address City/State

Service Facility Inpatient ☐ Outpatient ☐ Office ☐ Home ☐ Other ☐

Service Facility Address City/State

Ph# ( ) Service Facility NPI

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REQUESTED PROCEDURES AND/OR SERVICES

If you need more codes authorized, please attach a separate form.

Diagnosis Code	CPT/ HCPCS Code	# Units/ Visits	DME Purchase Price	Procedure/ Device Description*

* **If hardware and/or implant will be used, please provide brand and model # in the relevant procedure/device description (last column in the above table).**

Anesthesia: Yes ☐ No ☐

If yes, specify type: Local ☐ Conscious Sedation ☐ General ☐

Assistant Surgeon: Yes ☐ No ☐ **If yes**, assistant surgeon name/NPI:

Surgical Approach: Open ☐ Laparoscopic ☐ Endoscopic ☐ Robotic ☐ Other ☐

Will a computerized navigation system be used? Yes ☐ No ☐ N/A ☐

If this request is for PT, OT, or ST, please indicate the number of visits for each type:

Rehabilitative visits Habilitative visits Visits already used

DOCUMENTATION SUBMISSION

Submit completed form with relevant clinical notes and medical necessity information via email as follows:

- For Commercial Plans (Large Employer, Small Employer, Self-Funded, and Individual): **commercialUMintake@imail.org**
- For SelectHealth Community Care (Medicaid/CHIP): **medicaidUMintake@imail.org**
- For SelectHealth Advantage (Medicare): **medicareUMintake@imail.org**

Need other submission options? Call **800-442-5305** for assistance.

selecthealth.