Select Health

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 Select Health receives this form, we have these decision days to make a benefit determination (unless an expedited review is requested):

- **For Commercial Plans:** 14 days (Utah), 2 business days (Idaho), 10 days (Nevada), **5 business days** (Colorado)
- **For Medicare:** 14 days (All States)

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 days (see above) 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 Area Code and Ph # (complete ONLY if expedited request)

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

Today's Date _____ Dates of Service _____ to _____

Contact Name _____ Email _____

Ph # _____ Fax# _____

PATIENT INFORMATION

Patient Name _____ Date of Birth (mm/dd/yr) _____

City/State _____

Primary Health Insurance _____ ID# _____ Plan _____

Other Health Insurance _____ ID# _____ Plan _____

PROVIDER INFORMATION

Requesting Provider _____ NPI# _____ Area Code/Ph# _____

Complete Address _____

Service Provider _____ NPI# _____ Area Code/Ph# _____

Complete Address _____

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

If other, please specify: _____

Complete Address _____

Area Code/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

If other, please specify

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, Individual): commercialUMintake@imail.org
- For Select Health Community Care® (Medicaid/CHIP): medicaidUMintake@imail.org
- For Select Health Medicare: medicareUMintake@imail.org

NOTE: For ALL drug requests, complete the online form at selecthealth.org/pa for all lines of business, or fax to **801-650-3279** for Commercial, **801-650-3170** for Medicare, or **866-811-4997** for Medicaid.

Reduce turnaround time for preauthorization requests by using CareAffiliate®. Some requests even qualify for auto-approval. To learn more, email careaffiliate@selecthealth.org or visit https://selecthealth.org/providers/preauthorization/careaffiliate.

Select Health