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Request for Medical Preauthorization

•							
•	the form below, and submit via email (notes and medical necessity information	(see email addresses at the end of this					
Once SelectHealth® receive benefit determination unles							
This request is (check one)	using CareAffiliate®. Some preauthorization requests even						
IF you checked "URGENT," person who can immediate	· · · · · · · · · · · · · · · · · · ·						
number or answering service from a medical provider de	To learn more, email careaffiliate@selecthealth.org.						
• Jeopardize the life or healt							
	ility to regain maximum function; and/overe pain and inadequate management of						
	nplete ONLY if expedited request)()					
* Scheduling issues DO NOT meet cr	riteria for "URGENT."						
Today's Date	Dates of Service t	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/S	City/State					

Service Facility NPI

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(s) and model number(s) below:

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 indi	cate the <u>numbe</u> i	r of visits for	each type	e: Rehabilitative visits					
Habilitative visits	Visits already us	sed								

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.

