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 **14 days** (in Utah), **2 business days** (in Idaho), **10 days** (in Nevada), or **5 business days** (in Colorado) 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 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

Reduce turnaround time for preauthorizations by using CareAffiliate®. Some preauthorization requests even qualify for auto-approval. To learn more, email **careaffiliate@selecthealth.org**.

Select Health