# COLORADO PRIOR AUTHORIZATION REQUEST FORM

Fax the completed form to: 866-529-0934. Call 877-895-2705 if you have questions.

Please fill in every field; requests cannot be processed if they are missing Clinical Information, CPT or ICD codes.

This form is available online: http://providers.kaiserpermanente.org/html/cpp_cod/authorizationstoc.html

## 1. FORM COMPLETED BY:

| Completed By (Print) | Phone: | Fax: | Date: |
|---|---|---|---|

## 2. MEMBER INFORMATION:

| Kaiser #: | Last Name: | First Name: | |
|---|---|---|---|
| ☐ CHP+ Member | Date of Birth: | Phone: | |
| Address: | City: | State: | Zip: |

## 3. PRIORITY OF REQUEST:

| ☐ Routine (processed within 14 days)<br>☐ Urgent (care required within 72 hours) | | | | Referred to Place of Service (Facility or Group Name): |
|---|---|---|---|---|
| ☐ Surgery | ☐ Outpatient | ☐ Inpatient | ☐ DME | **Patient testing for or is Transplanted** ☐ **Yes** ☐ **No** |
| ☐ Modification; Existing Referral #: | | | | ☐ Renewal of Authorization; Existing Authorization #: |

## 4. PROVIDER INFORMATION:

| **Referred By** | | |
|---|---|---|
| Physician: | | |
| Specialty: | | |
| Phone: | | |
| Fax: | | |
| Address: | | |
| City: | State: | Zip: |

| **Referred To** | | |
|---|---|---|
| Physician: | | |
| TIN: | NPI: | |
| Specialty: | | |
| Phone: | | |
| Fax: | | |
| Address: | | |
| City: | State: | Zip: |

## 5. SERVICE INFORMATION:

| Start Date: | End Date: | |
|---|---|---|
| Diagnosis ICD Code(s): | Diagnosis Description: | |
| CPT/HCPCS Code(s) | Procedure or Description | Quantity/# of Visits |
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

## 6. COMMENTS:

Revision Nov 2019