

# Prior-Authorization Form (Referral Request)



Attn: UM Department – Referral Coordinator  
 Phone: 206-774-5650, Option 1  
 Fax: 206-774-5830

	Date:
Patient Name:	DOB:
Insurance ID #:	Patient's PCP:

### REFERRAL/SERVICES REQUESTED

<b>Inpatient:</b> <input type="checkbox"/> Surgical procedures <input type="checkbox"/> Inpatient Admits <input type="checkbox"/> Rehab	<b>Outpatient:</b> <input type="checkbox"/> Surgical procedures <input type="checkbox"/> PT, OT & ST <input type="checkbox"/> Imaging <input type="checkbox"/> Wound Care	<b>Other Services:</b> <input type="checkbox"/> Home Health <input type="checkbox"/> Home Infusion <input type="checkbox"/> Skilled Services (SN/PT/OT/ST)	<input type="checkbox"/> Consultation <input type="checkbox"/> Office Visit Follow-up <input type="checkbox"/> DME: <i>Please fax Prior-Auth Form &amp; Rx to 206-568-6550</i>
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Service is:	<input type="checkbox"/> Elective/Routine <input type="checkbox"/> Expedited/Urgent*	<b>*Definition of Expedited/Urgent:</b> <i>The delay of treatment could jeopardize the life and health of patient, jeopardize patient's ability to regain maximum function or subject patient to severe pain that cannot be adequately managed without the care or treatment requested.</i>
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<b>Behavioral Health:</b> <input type="checkbox"/> <b>Inpatient:</b> <i>If patient requires inpatient hospital treatment for mental health needs, please send to nearest ED for evaluation</i>	<input type="checkbox"/> <b>Chemical Dependency (CD):</b> <i>If patient requires CD treatment, they must be assessed by a CD professional to determine appropriate level of care as part of their admission process</i>	<input type="checkbox"/> <b>Eating Disorder/Residential Treatment:</b> <i>Coordination for these services managed by Behavioral Health Case Manager</i>
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### PROCEDURE INFORMATION

ICD-10 Code and Description:	
CPT/HCPCS Code and Description:	
Number of visits requested:	Date of Service:

### REFERRED FROM: ORDERING/REFERRING PHYSICIAN INFORMATION

Name:	Contact Name:		
Address:	Specialty Department:		
TIN:	NPI:	Phone:	Fax:

### REFERRED TO: REFERRING FACILITY/ PHYSICIAN INFORMATION

Name:	Contact Name:		
Address:	Specialty Department:		
TIN:	NPI:	Phone:	Fax:

**SUPPORTING DOCUMENTATION IS REQUIRED!** *If not received within 48 hrs, referral may be denied for missing information*

### FOR INTERNAL USE ONLY

Date:	Auth. #:	<input type="checkbox"/> Approved	<input type="checkbox"/> Denied
Valid date from:	Valid date to:	Number of visits:	

Notes/Comments:

Processed by \_\_\_\_\_