



COLORADO PRIOR AUTHORIZATION REQUEST FORM

Fax the completed form to 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:	
<input type="checkbox"/> CHP+ Member	Date of Birth:	Phone:	
Address:	City:	State:	Zip:

3. PRIORITY OF REQUEST:

<input type="checkbox"/> Routine (processed within 14 days)		Referred to Place of Service (Facility or Group Name):
<input type="checkbox"/> Urgent (care required within 72 hours)		
<input type="checkbox"/> Surgery	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Inpatient
<input type="checkbox"/> Modification; Existing Referral #:		<input type="checkbox"/> DME Patient testing for or is Transplanted <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> 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: