



COLORADO PRIOR AUTHORIZATION (PRE-CERTIFICATION) 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:

Name (Print):	Phone:	Fax:	Date:
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2. MEMBER INFORMATION:

Medical Record Number:	Last Name:	First Name:	
Date of Birth:	Phone:		
Address:	City:	State:	Zip:

3. PRIORITY OF REQUEST:

<input type="checkbox"/> Routine (care required within 3 to 15 days)	<input type="checkbox"/> Modification; Existing Authorization #:			
<input type="checkbox"/> Urgent (care required within 24 to 72 hours)	<input type="checkbox"/> Renewal of Authorization; Existing Authorization #:			
<input type="checkbox"/> Post Service (service has been rendered)	Is this a continuity of care request: <input type="checkbox"/> Yes or <input type="checkbox"/> No			
<input type="checkbox"/> Pre-Service (In-Office Procedures/Service, Medication and Radiology)	<input type="checkbox"/> Post-Service (Home Health, SNF, LTACH and AIR)	<input type="checkbox"/> Durable Medical Equipment	<input type="checkbox"/> Observation <input type="checkbox"/> Transplant	<input type="checkbox"/> Initial/Concurrent Hospital Admission
Behavioral Health/SUD Services:		Pre-Service Surgery:		
<input type="checkbox"/> Residential	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Partial Hospital	<input type="checkbox"/> ASC	<input type="checkbox"/> Inpatient
<input type="checkbox"/> Intensive Outpatient	<input type="checkbox"/> Inpatient	<input type="checkbox"/> Outpatient		

4. PROVIDER INFORMATION:

Check box if treating provider is not contracted with Kaiser Permanente.

Requesting Provider		
Physician:		
Specialty:		
NPI:		
Phone:		
Fax:		
Address:		
City:	State:	Zip:

Treating Provider	
Physician:	
Facility Name:	
TIN:	NPI:
Specialty:	
Phone:	
Fax:	
Address:	

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.		

6. COMMENTS:
