



# Precertification Request Form

Please use MCS Electronic System whenever available. Otherwise, use form below.

Date of Request: \_\_\_\_\_

PHP Utilization Management

Date of Service: \_\_\_\_\_

Phone 720.612.6600 | Fax 303.605.1545

|                                                                                                                                                      |                                                                                                                                                                                                                                                                                                       |
|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>ROUTINE</b><br>CMS regulations for processing a Routine request is 14 business days and 72 hours for Part B Medications. | <input type="checkbox"/> <b>URGENT*</b><br>CMS regulations for processing an Urgent request is 72 hours and 24 hours for Part B Medications. Please reserve Urgent requests to those that are medically urgent in nature.<br><b>*NOTE: Urgent requests will be given a 10-day authorization only.</b> |
|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

To avoid delays in processing time, please ensure all supportive clinical information is provided with request submission.

| Member Info:                                                                                                                                                                                                                                                     |                       |    |    |    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|----|----|----|
| Last Name: _____                                                                                                                                                                                                                                                 | Insurance ID #: _____ |    |    |    |
| First Name: _____                                                                                                                                                                                                                                                | DOB: _____            |    |    |    |
| Requesting Provider Info:                                                                                                                                                                                                                                        |                       |    |    |    |
| Provider Name: _____                                                                                                                                                                                                                                             | Phone: _____          |    |    |    |
| Office Contact: _____                                                                                                                                                                                                                                            | Fax: _____            |    |    |    |
| Prior Authorization:                                                                                                                                                                                                                                             |                       |    |    |    |
| <input type="checkbox"/> <b>Procedure/Service:</b><br><input type="checkbox"/> Outpatient Procedure <input type="checkbox"/> Inpatient Procedure<br>Procedure/Service Requested: _____<br>Facility/Provider: _____                                               |                       |    |    |    |
| <input type="checkbox"/> <b>DME:</b> Facility/Provider: _____                                                                                                                                                                                                    |                       |    |    |    |
| <b>CPT Code or Procedure</b>                                                                                                                                                                                                                                     | 1.                    | 2. | 3. | 4. |
| <b>ICD-10 or Diagnosis</b>                                                                                                                                                                                                                                       | 1.                    | 2. | 3. | 4. |
| <b>Provide pertinent clinical information including history, current signs and symptoms, duration, past treatments, results of recent diagnostics or lab, proposed treatment plan. Please attach additional information as needed.</b><br><br>_____<br><br>_____ |                       |    |    |    |

**\*\*IMPORTANT\*\***

To ensure a timely response/determination on your request, please fax all supporting clinicals with request as soon as possible to PHP PA Department at 303-605-1545. This will help facilitate processing of request and decrease unnecessary phone calls.

This referral is not a guarantee of payment. Coverage will be determined based on eligibility and availability of remaining benefits at the time of service