CDPHP® Utilization Review Prior Authorization/Medical Exception Form

Fax or mail this form to:

CDPHP Utilization Review Department, 500 Patroon Creek Blvd., Albany, NY 12206-1057

Phone: (518) 641-4100 **Fax: (518) 641-3207**

**** DO NOT USE THIS FORM FOR MEDICATION REQUESTS****

Patient Information:

Last Name: _____ First Name: _____

Member ID #: _____ Date of Birth: _____

Service Date(s) or Service Period: _____

Patient Diagnosis/Diagnoses and ICD-10 Codes: _____

Ordering/Referring Provider:

Name: _____ Address: _____
NPI #: _____ Tax ID #: _____

Phone #: _____ Fax #: _____

Nurse Contact: _____ Ext: _____ Date: _____

Servicing Provider:

Name: _____ Address: _____
NPI #: _____ Tax ID #: _____

Phone #: _____ Fax #: _____

Servicing Facility/Vendor (if applicable):

Name: _____ Address: _____
NPI #: _____ Tax ID #: _____

Phone #: _____ Fax #: _____

To ensure timely processing of your request, please include all information.

1. Requesting service (e.g., out-of-network consultation/follow-up office visit, durable medical equipment, procedure). If the request is for an office or surgical procedure, durable medical equipment, or medical supplies, CPT/HCPCS codes must be identified:

_____
_____

2: Briefly describe the patient-specific rationale for the request:

_____
_____
_____
_____

In addition, supporting clinical documentation (including pertinent consultation/office visits, labs, radiology, etc.) must be submitted via fax or mail. Photos must be mailed.

Contact information for submitter of request:

Name: _____ Phone # _____ Ext: _____

Address: _____ Fax #: _____

Date: _____