KAISER PERMANENTE®

COLORADO PRIOR AUTHORIZATION REQUEST FORM

Fax the completed form to: **866-529-0934**. Call **855-364-3184** if you have questions.

Please fill in every field; requests **cannot** be process 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:	
Date of Birth:	Phone:		
Address:	City:	State:	Zip:

3. PRIORITY OF REQUEST:

☐ Routine (processed between 3 to 15 days) ☐ Urgent (care required within 24-72 hours) ☐ Retro review (Service has been rendered)	☐Modification; Existing Authorization #: ☐Renewal of Authorization; Existing Authorization #: Is this a continuity care request: ☐Yes or ☐No

☐Pre-service (In-Office Procedures/ Service, Medication and Radiology). Medications are processed within 1-5 days	☐Post-Service (Home Health, SNF, LTACH and AIR	☐Durable Medical Equipment	☐Observation ☐Transplant	☐ Initial/Concurrent Hospital Admission
Behavioral Health/SUD Services: ☐Residential ☐ Outpatient ☐Partial Hospital ☐Intensive Outpatient ☐Inpatient		Pre-Service Surgey: ☐ASC ☐Inpatient ☐Outpatient		

4. PROVIDER INFORMATION:

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

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:
