CDPHP® Utilization Review Prior Authorization/Medical Exception Form

Fax or mail this form to:

CDPHP Utilization Review Department, 6 Wellness Way, Latham, NY 12110

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

Please note: *If the requirement for prior authorization for a particular service or procedure has been removed by CDPHP, there is no need for you to submit this form for consideration. However, before performing the service or procedure, you must still ensure that your patient meets the medical necessity criteria outlined in the applicable CDPHP Resource Coordination policy.*

If you believe your patient's situation presents a unique exception to a policy, please submit this form for review, along with clinical documentation, and check the box below.

☐ *Medical exception*

Patient Information:

Last Name: ______________________ First Name: ______________________

Member ID #: ______________________ Date of Birth: ______________________

Service Date(s) or Service Period: ______________________

Is this request related to facility discharge planning? ☐ **Yes** ☐ **No**

Patient Diagnosis/Diagnoses and ICD-10 Codes:

Prescribing/Ordering/Referring Provider:

Name: ______________________

Street Address: ______________________

City, State, Zip: ______________________

Email: ______________________

NPI #: ______________________ Tax ID #: ______________________

Phone #: ______________________ Fax #: ______________________

Nurse Contact: ______________________ Ext: ________ Date: ______________________

(continued on next page)

Servicing/Requesting Provider:

Name: ______________________________

Street Address: ______________________________

City, State, Zip: ______________________________

Email: ______________________________

NPI #: ______________________ Tax ID #: ______________________

Phone #: ______________________ Fax #: ______________________

Place of Service:

☐ **Inpatient Facility** ☐ **Outpatient Facility** ☐ **Office**

Servicing Requesting Facility/Vendor (if applicable):

Name: ______________________________

Street Address: ______________________________

City, State, Zip: ______________________________

NPI #: ______________________ Tax ID #: ______________________

Phone #: ______________________ Fax #: ______________________

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

1. Description of requesting service, in addition to the quantity requested (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 symptoms and duration, medical justification, and summary of clinical findings for the request:

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

Contact information for submitter of request:

Name: ______________________ Phone: ______________________ Ext: ________

Street Address: ______________________ Fax: ______________________

City, State, Zip: ______________________ Order Date: ______________________