Health Plan Name/Logo

State of Vermont
Uniform Medical Prior Authorization Form

Urgent Request ☐
Non-Urgent Request ☐

Instructions: Please complete all fields and submit all additional treatment information and/or medical notes that support your request for benefits. If you need more room, you may attach additional pages or forms. Send or fax this information to the member's health plan in advance of the proposed services. Please refer to information provided on the health plans' website for submission instructions and contact information.

Patient/Member Information

First Name: **Middle Initial:** **Last Name:**		
Member ID#:	**DOB** *(MM/DD/YYYY)*: ____/____/_____	**Gender:** Male ☐ Female ☐
Address: **Apt.#:**		
City: **State:** **Zip:** **Telephone #:**		

Referring/Requesting Provider Information	Rendering/Attending Provider Information
First Name: **Last Name:**	**First Name:** **Last Name:**
NPI/TIN #:	**NPI/TIN #:**
Group/Practice Name:	**Group/Practice Name:**
NPI/TIN #:	**NPI/TIN #:**
Address: **Suite #:**	**Address:** **Suite #:**
City: **State:** **Zip:**	**City:** **State:** **Zip:**
Office Contact/ Person Completing Form:	
Telephone #:	**FAX #:**

Required Clinical Information

Date of Request:	**Is this request for Out-of-Network services?** Yes ☐ No ☐
Type of Service Requested: Medical Admit ☐ Mental Health/Substance Abuse Admit ☐ Surgery ☐ Diagnostic Medical Test ☐ SNF ☐ PT/OT/Speech Therapy ☐ Chiropractic ☐ Home Health ☐ Diagnostic Imaging ☐ Mental Health OP ☐ DME ☐ Vision/Glasses ☐	
Date Diagnosed:	**Place of Service:** Inpatient ☐ Outpatient ☐ Office ☐ Other ☐ specify:
Proposed Date(s) of Service:	
Primary Diagnosis:	**Primary Diagnosis Code:**
Secondary Diagnosis:	**Secondary Diagnosis Code:**
Proposed Inpatient Treatment Days: **From:** **To:**	**Proposed Outpatient Treatment Visits:** **Number:** **From:** **To:**
Proposed Procedure or Test:	**CPT/HCPCS or Revenue Code:**
Requested DME:	**DME Duration:**
DME Purchase Price: $	**DME Monthly Rental Price: $**
DME CPT/HCPCS Code:	

Additional Clinical Information Attached: ☐