



Referral/Pre-Authorization Form - PSD

Phone# 800-207-1018

Fax# 970-224-0128

Referrals (Physicians to Physician)

Pre-Authorization (Services)

*******CLINICAL notes required for Pre- authorizations*******

Patient Name _____ DOB _____ Member ID _____

PCP/Referring Physician (Please Print)

Date of request

Referred Provider

Referred Facility

Diagnosis

ICD10

Services Requested

CPT/ HCPC Codes

Surgery requests: Date of Service: _____ Inpatient _____ Outpatient _____

Physician Signature _____ Date _____

Contact person: _____ Telephone # _____

For administration documentation only:

APPROVED: UM# _____ DENIED: _____ PENDED: _____

Comments: _____

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