UCHealth Plan Administrators
UNIVERSITY OF COLORADO HEALTH

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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