UCHealth

PLAN ADMINISTRATORS

UCHealth Plan Administrators
REFERRAL/PRIOR-AUTHORIZATION FORM

Phone: 970-224-4600 or toll free at 800-207-1018 Fax #: 970-224-0128

Patient Name: _____ DOB: _____
(last, first)

Member ID Number: _____

_____ _____
PCP/Referring Physician Date of request

_____ _____
Referred to Provider Referred to Facility

_____ _____
Diagnosis ICD-10 code

_____ _____
Services requested CPT/HCPC code

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

Physician Signature: _____ Date: _____

Contact person: _____ **Contact phone #:** _____

Contact person fax #: _____

Clinical notes required for authorizations

FOR ADMINISTRATION DOCUMENTATION ONLY:
APPROVED: _____ DENIED: _____ PENDED: _____ AUTH NUMBER: _____
COMMENTS: