



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:

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