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 (* Required Field)

*First Name: _____ Middle Initial: _____ *Last Name: _____

*Health Insurance ID#: _____ *DOB (MM/DD/YYYY): ___/___/_____ *Gender: Male ☐ Female ☐ Unknown ☐

*Address: _____ Apt.#: _____

*City: _____ *State: _____ *Zip: _____ Telephone #: _____

Referring/Requesting Provider Information

First Name: _____ Last Name: _____

NPI/TIN #: _____ Specialty: _____

Group/Practice Name: _____

NPI/TIN #: _____

Address: _____ Suite #: _____

City: _____ State: _____ Zip: _____

Rendering/Attending Provider Information

First Name: _____ Last Name: _____

NPI/TIN #: _____ Specialty: _____

Group/Practice Name: _____

NPI/TIN #: _____

Address: _____ Suite #: _____

City: _____ State: _____ Zip: _____

Office Contact/
Person Completing Form: _____

Telephone #: _____ FAX #: _____

Required Clinical Information (* Required Field)

*Date of Request: _____ Is this request for Out-of-Network services? Yes ☐ No ☐

*Type of Service Requested

Inpatient Care:
Medical Admit ☐
Mental Health/Substance Abuse Admit ☐
OB ☐
Surgery ☐ Oral Surgery ☐

Outpatient/Office Care:
Acupuncture ☐
Chiropractic ☐
Infusion/Oncology Drugs ☐
Mental Health/Substance Abuse ☐

Therapies:
Occupational Therapy ☐
Physical Therapy ☐
Speech Therapy ☐
Cardiac Rehab ☐

Testing:
Diagnostic Imaging ☐
Diagnostic Medical Test ☐

Other:
DME ☐ SNF ☐ Home Health ☐ Vision/Glasses ☐ Other ☐ - please specify: _____

*Date Diagnosed: _____

*Place of Service:
Inpatient ☐ Outpatient ☐ Office ☐ Other ☐ - specify: _____

*Proposed Date(s) of Service: From: _____ To: _____

*Facility Where Service Will be Performed: _____

*Proposed Number of Inpatient Treatment Days: _____

*Proposed Number of Outpatient Treatment Visits: _____

*Primary Diagnosis: _____

*Primary Diagnosis Code: _____

*Secondary Diagnosis: _____

*Secondary Diagnosis Code: _____

*Name of Proposed Procedure or Test: _____

*CPT/HCPCS or Revenue Code: _____

*Requested DME: _____

*DME CPT/HCPCS Code: _____

*Requested DME Duration (Date(s) of Service): _____

*DME Purchase Price: $ _____

*DME Monthly Rental Price: $ _____

Additional Clinical Information Attached: ☐ (No. of pages ____)