Prior to submitting this request:
Confirm that patient has a current referral from PCP.

Denver-North
Phone: 1-888-685-8491, TTY 711 Fax: 1-844-206-5736 Email: colorado.medmgt@optum.com
Instructions: Please ensure each section below is completed and all required fields are filled-in appropriately.

Type of request (select one)	The following patients require a pre-op evaluation to be done prior to any ELECTIVE SURGICAL ADMISSION:
£ STANDARD—For prompt determination, submit ALL STANDARD requests using the online portal. £ EXPEDITED—ONLY submit EXPEDITED requests when the health care provider believes that waiting for a decision under the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.	1) > 65 yrs 2) < 65 yrs with comorbidity PCP NOTIFIED: £ YES £ NO

Please attach applicable supporting documents, including, but not limited to: medical history, labs, X-rays and diagnostic results, **physician's** notes and orders, progress report, and letter of medical necessity.
Missing or insufficient documents may delay the review process.

Patient information (ALL required)
Name:_____ Member ID:_____
Date of birth:_____ PCP:_____

Requesting provider: Contact name / phone: _____
Name: (Required – please print) _____
Phone: (Required)_____ FAX: (Required)_____ (Determination will be sent to this number.)
Address: (Required)_____ (Correspondence will be sent to this address.)

Servicing provider:
Name: (Required – please print) _____
Phone: (Required)_____ FAX: (Required)_____ (Determination will be sent to this number.)
Address: (Required)_____ (Correspondence will be sent to this address.)

Servicing facility:
Name: (Required – please print) _____
Phone: (Required)_____ FAX: (Required)_____ (Determination will be sent to this number.)
Address: (Required)_____ (Correspondence will be sent to this address.)

Date of service:
Start date:_____ End date: _____ # of visits:_____

Location of service (select one):
£ Outpatient facility £ Inpatient facility £ Home £ Office £ Ambulatory Surgical Center (ASC)

Type of service (select one):
£ Medicine/injectable £ Home health £ DME £ Out of network/out of area £ Diagnostic test £ Procedure

Codes:
Diagnosis:_____ ICD 10 code(s):_____
Procedure:_____ CPT code(s):_____

Additional CPT codes (if applicable): _____

Physician reviewers and staff are available through the MSO Mon-Fri 8-5 p.m. for any UM issues, questions or discussions regarding a specific case at 1-888-685-8491or fax 1-844-206-5736. Any voicemails left after business hours will be returned the next business day. If urgent, please page an RN case manager at 1-303-817-7929. A peer-to-peer review will be made available within five business days of a request.

This form or authorization does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, benefits, contractual limitations, PROVISIONS, and exclusions. REVIEW of medical information, and/or medical records can be requested. Please VERIFY benefits and eligibility prior to rendering SERVICES.