PRIOR AUTHORIZATION (PRE-CERTIFICATION) REQUEST FORM

Please fill in each section as thoroughly as possible; requests cannot be processed if they are missing CPT or ICD codes. In addition, you must attach any necessary clinicals separate to this form. Kaiser Permanente (KP) reserves the right to downgrade urgent requests based on medical necessity.

NW CHOICE PRODUCTS *(Optional – Only answer if request is for a member enrolled on a PPO or POS NW Choice Product)*

PPO (Preferred Provider Organization)/OON (Out of Network) Request: Yes No

1. FORM COMPLETED BY:

Name (Print):	Phone:	Fax:	Date:

2. MEMBER INFORMATION:

KP Medical Record Number:	Last Name:	First Name:	Middle Initial:
Date of Birth:	Phone:		
Address:	City:	State:	Zip:

3. PRIORITY OF REQUEST:

☐ Routine

☐ Urgent* *By selecting urgent, you are indicating delaying this referral could seriously jeopardize the life or health, the ability to regain maximum function, or lead to ongoing severe pain for the patient.*

☐ Post Service/Retrospective

For Existing Authorizations:

Authorization #:

☐Renewal of Authorization ☐Modification of Authorization

Notes:

☐ Is this a continuity of care request?

**For Continuity of Care requests, please attach any existing authorization(s) from the member's previous health plan, if applicable.*

Please select one box that most appropriately aligns with the requested service:

Acute Care: ☐ Initial Hospital Admission ☐ Concurrent Hospital Review ☐ Observation ☐ Hospice ☐ Transplant

Outpatient: ☐ Service ☐ Transplant ☐ PT/OT/ST ☐ Hospice ☐ Palliative Care ☐ Clinically Administered Medications ☐ Durable Medical Equipment ☐ ICF Part B (include facility name and address) ☐ Home Infusion

Behavioral Health: ☐ Inpatient ☐ Outpatient ☐ Partial Hospital ☐ Intensive Outpatient ☐ Residential

**For BH in Maryland and KPNW, please use The Uniform Treatment*

Post-Acute: ☐ Home Health Care ☐ LTACH ☐ Acute Inpatient Rehab ☐ Skilled Nursing Facility

Pre-Service: ☐ In-Office Procedure ☐ Clinically Administered Medications (Non-Self Admin) ☐ Radiology ☐ Ground/Air Transportation

Pre-Service Surgery: ☐ ASC ☐ Outpatient ☐ Inpatient

4. PROVIDER INFORMATION

☐ **Select this checkbox if it is okay to substitute a Kaiser Permanente or another in-network provider if the chosen referred-to provider is not in the member's network or if the requested services are available within Kaiser Permanente**

Referring/Requesting Provider		**Referred-to/Treating Provider**	
Clinician:		Clinician:	
Facility/Office Name:		Facility Name:	
Specialty:		Specialty:	
TIN:	NPI:	TIN:	NPI:
Phone:	Fax:	Phone:	Fax:
Address:		Address:	

5. SERVICE INFORMATION

Start Date:					End Date:		
Diagnosis ICD-10 Code(s):							
CPT/HCPCS Code(s):	Requested quantity:	CPT/HCPCS Code(s):	Requested quantity:	CPT/HCPCS Code(s):	Requested quantity:	CPT/HCPCS Code(s):	Requested quantity:
Industrial Illness/Injury or Third-Party Liability (TPL) ☐ YES ☐ NO							

6. COMMENTS

☐ Click here to indicate that clinical information/medical records are attached *(Clinical information/medical records should be included with prior authorization request for review)*

PRIOR AUTHORIZATION (PRE-CERTIFICATION) REQUEST FORM

Please fill in each section as thoroughly as possible; requests cannot be processed if they are missing CPT or ICD codes. In addition, you must attach any necessary clinicals separate to this form. Kaiser Permanente (KP) reserves the right to downgrade urgent requests based on medical necessity.

7. CONTACT INFORMATION