PeakHealth

Outpatient Authorization Form

Please provide the information below for the member.

Member ID Number:		**Member Group Number (Optional):**
Member Last Name:	**Member First Name:**	**Member Date of Birth: (MM/DD/YYYY):**
Member Address:		**Member Phone Number:**

Requesting Provider's Name:	**TIN/ NPI:**	**Provider Group (if applicable):**
Requesting Provider's Address:		
Requesting Provider's Phone Number:		**Requesting Provider's Fax Number:**
Service Provider or Facility Name:		**Service Provider or Facility TIN/NPI:**
Service Provider or Facility's Address:		
Service Provider or Facility's Phone Number:		**Service Provider or Facility's Fax Number:**

Please advise if the request is: ☐ Pre-Service ☐ Post-Service ☐ Concurrent

Request Type: ☐ Initial ☐ Renewal

Are you requesting an expedited review: ☐ Yes ☐ No

To allow us to review and respond to your request, please provide the following information.

Date(s) of Service:	**Planned Service or Procedure:**
CPT/HCPCS/Service(s) and/or Drug(s) being requested (for drugs, please provide specific strengths, dosing, and quantities requested as well as administration codes):	
Diagnosis Code(s):	
Number of visits, frequency, and duration (if applicable):	
Additional Details for request:	

Type of Service: ☐ Therapies ☐ HBO ☐ IMRT ☐ Pain Management
☐ Sleep Studies ☐ MRI/MRA ☐ PET Scan ☐ DME
☐ Other (Specify) _____

For MRI Requests Only: ☐ With Contrast ☐ Without Contrast ☐ With and Without Contrast

For PET Scan Requests Only: ☐ Initial Staging ☐ Restaging ☐ Response to Treatment

For DME Requests Only, please include detailed usage instructions:

Note: To obtain a review, submit this form and any supporting documentation that would be helpful in the evaluation of your request including invoices, correspondence, medical records, or other clinical documents related to the service requested. For potential experimental and investigational procedures please include any published medical literature to support the procedure or item's use in the treatment of the member's diagnosis.

You may submit a referral electronically via Epic or the PeakProvider Secure Portal.

You may also submit your request by fax or by mail:

Peak Health Utilization Management Department

1085 Van Voorhis Rd, Suite 300

Morgantown, WV 26505

Fax: 304-974-3191

If requesting an expedited review or for assistance with completing this form, please contact Peak Health Provider Service at 1-833-9-MYPEAK (1-833-969-7325), Monday through Friday, 8:00am to 5:00pm ET, excluding holidays.

Signature: _____ Date: _____

Please Note: Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injury, defraud, or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.