

Fax to: Rocky Mountain Health Plans
 Statewide 970-254-5738 or 877-201-7302

Pregnancy Notification/Procedure Form

The preauthorization for the services noted in this form is only for the time period during which the patient remains eligible on the patient's current health benefit plan or for a shorter period as specified in this form. The underwriting plan is not financially responsible for the services that are preauthorized if the patient is not eligible at the date services are provided. Further, as permitted by applicable law, this preauthorization is subject to concurrent review as to medical necessity, appropriateness, and efficacy and coverage for services being provided, and is subject to terms and conditions in the member's health benefits contract, including but not limited to coordination of benefits provisions, pre-existing conditions and limitations, and any agreements between the health plan and the health care provider. Billing for the services preauthorized on this form is subject to nationally standardized rules for coding and paying health services as used by Rocky Mountain Health Plans.

Date: _____

Member Information:

Member Name: _____ Date of Birth: _____

Member ID or Medicaid #: _____ EDC: _____

Date of Service: _____ Facility for Delivery/Procedure: _____

ICD-9/Diagnosis Code(s): _____ CPT/Procedure Code(s): _____

Reason for High Risk Diagnosis: _____

Provider Information:

Provider Name: _____

Provider Phone #: _____ Provider Fax #: _____

Person Completing Form: _____ Primary Care Physician: _____

For Rocky Mountain Health Plans Use Only: *(will be completed by Rocky Mountain Health Plans)*

Effective Date: _____ Plan Type: _____ Authorization #: _____

Called/Faxed: _____ Approved Date/Time: _____

Approved Denied By: _____

Reason Approved/Denied: _____

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