

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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