

THIS IS NOT AN APPROVAL. After validating the information on this form is correct, you must fax to the numbers below to submit the preauthorization request with supporting medical records. No payment will be issued for services without preauthorization.

Plans underwritten by Rocky Mountain HMO (RMHMO)
or Rocky Mountain HealthCare Options, Inc. (RMHCO)



DOC TYPE 1M

Preauthorization Request-For Use by Out of Network Providers Only

RMHP Statewide Fax: 800-262-2567 or 970-255-5681

New Request Revised Request of Approval #

To ensure your pre-service request is completed in a timely manner, please allow:

Medicaid — 10 days Medicare — 14 days CHP+ — 10 days Commercial — 15 days

Patient Name: _____ Member ID#: _____ - _____

Date of Birth: _____

Requesting Provider (Please use full name): _____

Provider Phone #: _____ Provider Fax #: _____

Billing Provider (Please use full name): _____ TIN #: _____

Billing Provider Phone #: _____ Provider Fax #: _____

Facility/office where service to be performed: _____ TIN #: _____

Address and Phone #: _____

Contact for Determination Notification: _____ Contact Phone #: _____

Services:

Inpatient surgery Observation Outpatient Surgery Office Transplant Evaluation Transplant Listing

If transplant, what organ? _____

Date of Service: _____

Diagnosis Code: _____ Diagnosis Description: _____

— Don't forget to attach clinical notes with this request to avoid processing delays. —

CPT Code(s)/HCPCS Code(s): _____ Name and Quantity: _____

Description of Services: _____

For medications or enteral nutrition formula/supplies only: Where will the member pick up the supplies/items?

Pharmacy Name: _____ Store Number: _____

Address: _____

Phone #: _____ Fax #: _____

The preauthorization for 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. Rocky Mountain Health Plans is not financially responsible for the services that are preauthorized if the patient is not eligible on the date services are provided. Further as permitted by applicable law, this preauthorization is subject to concurrent review as to medical necessity, appropriateness or efficacy, and coverage for services being provided and is subject to the terms and conditions in the Member's Evidence of Coverage, including but not limited to, coordination of benefit provisions, preexisting conditions and limitations, and any agreements between Rocky Mountain Health Plans 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.

Confidentiality Notice:
This facsimile transmission (and/or documents accompanying it) may contain confidential, proprietary, and privileged information. This information is intended only for the use of the individual(s) named above. Any unauthorized review, use, disclosure, or distribution is prohibited. If you have received this transmission in error or cannot identify the recipient for distribution purposes, please notify RMHP immediately at 800-854-4558.