AUTHORIZATION REQUEST

INCOMPLETE FORMS CANNOT BE PROCESSED

Instructions: Please complete all sections of this form and fax to the VHP Utilization Management department with clinical notes and orders.

Fax #: 408.885.4875
Phone # 408.885.4647

Patient Information:

First Name: ______________ Last Name: ______________

Date of Birth: ______________ Health Plan ID: ______________

Address: ______________________________

Phone #: ______________

Referred To Provider:

Provider Name: ______________________________

Provider Address: ______________________________

Phone #: ______________ Fax: ______________

Facility:

Facility Name: ______________________________

Facility Address: ______________________________

Phone #: ______________ Fax: ______________

Request Type:

☐ Urgent ☐ Routine
☐ Retro Date of Service ________

Location of Authorization

☐ Inpatient ☐ Outpatient
☐ Home ☐ Laboratory
☐ Other

Services Requested

ICD 10 Codes: 1) __________ **2)** __________ **3)** __________

CPT/HCPC/Revenue Codes Requested	**# of Units**	**Services Requested and Reason:**
1. Modifier:		
2. Modifier:		
3. Modifier:		
4. Modifier:		

Referring Provider: ______________________________ **Date:** ______________

Provider Address: ______________________________

Phone #: ______________ **Fax #:** ______________

NOTE TO ALL PROVIDERS: This authorization is valid only if the patient is eligible on the date of service. Please recheck eligibility prior to delivering service. For VHP Commercial patients please call 408.885.4760 or 1.888.421.8444.