friday health plans

Colorado Prior Authorization (PA) Request
Form Fax completed form to: 1-888-500-1513
Phone number: 1-800-475-8466
Email: CO-medical@fridayhealthplans.com

*** = Required Information**

Requestor's Contact Name: _____ Requestor's Phone & Fax: _____

PATIENT INFORMATION

*Name: _____ *Date of Birth: _____

*Member ID Number: _____ *Member Phone Number: _____

*Preferred Language: ☐English ☐Spanish

*Service Is: ☐ **Elective/Routine** ☐ **Expedited/Urgent** ☐**Resubmission** ☐**Additional Services** _____**auth**
Note: Select Expedited/Urgent to prevent serious deterioration in health or ability to regain maximum function.

*REFERRAL SERVICE TYPE REQUESTED

Inpatient	Outpatient	Behavioral Health	Other
☐ Surgical Procedure	☐ Surgical Procedure	☐ Inpatient	☐ Home Health (SN/PT/OT/SP)
☐ Elective Admission	☐ Imaging/Diagnostic	☐ Partial Hospitalization	☐ Durable Medical Equipment
☐ Skilled Nursing Facility	☐ Infusion Therapy	☐ Intensive Outpatient	☐ Dental
☐ Rehabilitation	☐ Chemotherapy	☐	☐ Exception to Benefit
☐ Other	☐ Radiation		☐ Out of Network Exception
	☐ Transplant Eval/Listing		☐

PROCEDURE INFORMATION

***ICD-10** Diagnosis: _____ Diagnosis Description: _____

***CPT/HCPCS** Code and Description *(For PT, OT or ST, please indicate if Rehabilitative or Habilitative.)(Include units of measure/visits and please indicate if Robotic Assisted and include all implant codes)* _____

_____

* Date(s) of Service: _____ * Number of Visits: _____

PROVIDER INFORMATION

Ordering Provider: ☐ *Primary Care Physician*

*Name: _____ *NPI: _____ *TIN: _____

*Fax: _____ *Phone: _____

*Address: _____

Servicing Provider: ☐ *Same as Ordering*

*Name: _____ *NPI: _____ *TIN: _____

*Fax: _____ *Phone: _____

*Address: _____

Facility: ☐ *N/A*

*Name: _____ *NPI: _____ *TIN: _____

*Fax: _____ *Phone: _____

*Address: _____

Request for extension to authorization:

_____

ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NECESSITY. INCOMPLETE INFORMATION MAY DELAY THE PROCESS.

RETRO AUTHORIZATIONS CAN BE SUBMITTED UP TO 10 BUSINESS DAYS AFTER DATE OF SERVICE UNLESS EXTENUATING CIRCUMSTANCES ARE PRESENT.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.