# CDPHP® Utilization Review Additional Medical Record Submission

To submit additional records for medical services pre-authorization, please fax or mail this form to:

CDPHP Utilization Review Department
6 Wellness Way, Latham, NY 12110
Fax: (518) 641-3207 • Phone: (518) 641-4100

*Please note, **CDPHP cannot accept photographs via fax or email** due to image clarity. You may submit this form with photographs and/or complete medical records (up to 10MB max) via the secure CDPHP provider portal or by mailing to the Utilization Review address above.*

**To ensure timely processing of your request, please include all required information:**

**Patient Information:**

Last Name *(required)*: _____ First Name *(required)*: _____

Member ID #: _____ Date of Birth *(required)*: _____

Service Date(s) or Service Period (if known/applicable): _____

Date of original prior authorization request: _____

Name of intended recipient (if known/applicable): _____

Describe what is attached (required): e.g., supporting clinical documentation including pertinent consultation/office visits, lab results, radiology reports, photographs, etc.

_____

_____

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**Contact information for submitter of request:**

Contact Name: _____ Phone: _____ Ext: _____