



CDPHP® Utilization Review Prior Authorization/Medical Exception Form

Fax or mail this form to:

CDPHP Utilization Review Department, 500 Patroon Creek Blvd., Albany, NY 12206-1057

Fax: (518) 641-3207 • Phone: (518) 641-4100

Please note: If the requirement for prior authorization for a particular service or procedure has been removed by CDPHP, there is no need for you to submit this form for consideration. However, before performing the service or procedure, you must still ensure that your patient meets the medical necessity criteria outlined in the applicable CDPHP Resource Coordination policy.

If you believe your patient's situation presents a unique exception to a policy, please submit this form for review, along with clinical documentation, and check the box below.

Medical exception

Patient Information:

Last Name: _____ First Name: _____

Member ID #: _____ Date of Birth: _____

Service Date(s) or Service Period: _____

Is this request related to facility discharge planning? Yes No

Patient Diagnosis/Diagnoses and ICD-10 Codes:

Prescribing/Ordering/Referring Provider:

Name: _____

Street Address: _____

City, State, Zip: _____

Email: _____

NPI #: _____ Tax ID #: _____

Phone #: _____ Fax #: _____

Nurse Contact: _____ Ext: _____ Date: _____

(continued on next page)

Servicing/Requesting Provider:

Name: _____

Street Address: _____

City, State, Zip: _____

Email: _____

NPI #: _____ Tax ID #: _____

Phone #: _____ Fax #: _____

Place of Service:

Inpatient Facility Outpatient Facility Office

Servicing Requesting Facility/Vendor (if applicable):

Name: _____

Street Address: _____

City, State, Zip: _____

NPI #: _____ Tax ID #: _____

Phone #: _____ Fax #: _____

To ensure timely processing of your request, please include all information.

1. Description of requesting service, in addition to the quantity requested (e.g., out-of-network consultation/follow-up office visit, durable medical equipment, procedure). If the request is for an office or surgical procedure, durable medical equipment, or medical supplies, CPT/HCPCS codes must be identified.

2. Briefly describe the patient-specific symptoms and duration, medical justification, and summary of clinical findings for the request:

In addition, supporting clinical documentation (including pertinent consultation/office visits, lab results, radiology reports, etc.) must be submitted via fax or mail. Photos must be mailed.

Contact information for submitter of request:

Name: _____ Phone: _____ Ext: _____

Street Address: _____ Fax: _____

City, State, Zip: _____ Order Date: _____