VERMONT
DEPARTMENT OF FINANCIAL REGULATION

Pre-Service ☐ Elective ☐ Urgent ☐
Post-Service ☐ Non-Elective ☐ Non-Urgent ☐

Uniform Medical Prior Authorization Form

Important: Please read your insurer's (for individuals with commercial insurance) or Vermont Medicaid's (for Medicaid beneficiaries) specific instructions for completing this form.

Patient/Member Information (* Required Field)			
***First Name:** Click here to enter text. **Middle Initial:** . . . ***Last Name:** Click here to enter text.			
***Health Insurance ID#:** Click here to enter text.		***DOB:** Enter date.	**Gender Identity:**
***Address:** Click or tap here to enter text. **Apt. #:** Click or tap here to enter text.			
***City:** Enter City.	***State:** Choose an item.	***ZIP:** Enter ZIP.	***Tel.:** Enter Number.

Referring/Requesting Provider Information (* Required)		**Rendering/Attending Provider Information (* Required)**	
***First Name:** Enter text. ***Last Name:** Enter text.		***First Name:** Enter text. ***Last Name:** Enter text.	
***NPI/TIN#:** Enter text.	***Specialty:** Enter text.	***NPI/TIN#:** Enter text.	***Specialty:** Enter text.
***Address:** Enter text.	**Suite:** Enter text.	***Address:** Enter text.	**Suite:** Enter text.
***City:** Enter City.	***State:** Choose an item.	***City:** Enter City.	***State:** Choose an item.
***Tel.:** Click or tap here to ente	**Fax:** Click or tap here to enter	***Tel.:** Click or tap here to ente	**Fax:** Click or tap here to enter

***Office Contact/Person Completing Form:** Click or tap here to enter text.
***Telephone #:** Click or tap here to enter text. **Fax #:** Click or tap here to enter text.

Required Clinical Information (* Required Field)	
***Date of Request:** Click or tap to enter a date.	***Is this request for Out-of-Network Services? Y ☐ N ☐**

*Type of Service Requested (check all that apply)

Services:		**Therapies:**
Medical Admit: ☐	Obstetrics: ☐	Occupational Therapy: ☐
Mental Health/SUD: ☐	Immunotherapy Treatment: ☐	Physical Therapy: ☐
Oncology: ☐	Surgery (including Oral Surgery): ☐	Speech Therapy: ☐
Acupuncture: ☐	Transplant: ☐	Applied Behavior Analysis: ☐
	Chiropractic: ☐	

Testing/Imaging:	**Other:**
Diagnostic Imaging: ☐	DME:☐ SNF: ☐ Home Health: ☐ Vision/Glasses: ☐
Diagnostic Medical Test: ☐	Home Infusion: ☐ Other ☐ please specify: Click or tap here to enter text.
***Date Diagnosed:** Enter a date.	***Place of Service:** Telehealth/Audio Only: ☐ Inpatient: ☐ Outpatient: ☐ Office: ☐ Other: ☐ - specify: Enter text.

***Proposed Dates of Service:**	**From:** Enter a date. **To:** Enter a date.	***Facility Where Service Will be Performed:** Click or tap here to enter text.
***Proposed Number of Inpatient Treatment Days:** Number		***Proposed Number of Outpatient Treatment Visits:** Numb
***Primary Diagnosis:** Click or tap here to enter text.		***Primary Diagnosis Code:** Click or tap here to enter text.
***Secondary Diagnosis:** Click or tap here to enter text.		***Secondary Diagnosis Code:** Click or tap here to enter text.
***Name of Proposed Procedure:** Click or tap here to enter tex		***CPT/HCPCS or Revenue Code:** Click or tap here to enter t
***Requested Durable Medical Equipment (DME):** Click or tap here to enter text.		
***DME CPT/HCPCS Code:** Click or tap here to enter text.		***DME Duration:** Click or tap here to enter text.
***DME Purchase Price: $** Click or tap here to enter text.		***DME Monthly Rental Price: $** Click or tap here to enter te

Additional Clinical Information Attached: ☐ (No. of pages: Click or tap here to enter text.).