SIERRA HEALTH-CARE OPTIONS, INC.℠

PRIOR AUTHORIZATION REQUEST FORM

SHO UTILIZATION MANAGEMENT
PO BOX 15645, LAS VEGAS, NV. 89114-5645

PHONE: (800) 873-5791
FAX: (702) 243-8498

PATIENT INFORMATION:

PATIENT NAME: _____ DOB: _____

INSURED: _____ RELATION: _____ INSURED ID: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

PHONE: _____ EMPLOYER: _____ EFF DATE: _____

REQUESTING PROVIDER INFORMATION:

PROVIDER: _____ GROUP NAME: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

PHONE: _____ FAX: _____ CONTACT: _____ TIN: _____

PLACE OF SERVICE INFORMATION:

PROVIDER OR FACILITY: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

PHONE: _____ FAX: _____ TIN: _____

SERVICES: DOS: _____ OUTPT: ☐ INPT: ☐

SURGICAL: ☐ DIAGNOSTIC: ☐ SURGEON (IF APPLICABLE): _____

ICD-10 (IF KNOWN) _____

CPT (IF KNOWN) _____

CLINICAL FINDINGS:

PLEASE INCLUDE ALL CLINICAL INFORMATION, X-RAY REPORTS, DIAGNOSTIC TEST RESULTS SUPPORTIVE OF THE PROCEDURE(S) REQUESTED:

APPROVED:

CASE # _____ DATE: _____ PER: _____

ADDL. RCRDS REQ: _____

ROUTED TO MD: _____ PER: _____

THIS DETERMINATION CONSTITUTES A DEDISION ONLY AS TO THE "MEDICAL NECESSITY" OF THE PROPOSED TREATMENT, AS THE TERM IS DEFINED BY THE PLAN DOCUMENTS; THIS FORM IS NOT A GUARANTEE OF BENEFIT PAYMENT.