



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 DECISION 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.**

**\*\* NOTE \*\* THE INFORMATION CONTAINED IS PRIVILEGED AND CONFIDENTIAL. IF THIS COMMUNICATION HAS BEEN RECEIVED IN ERROR, PLEASE CONTACT US BY TELEPHONE IMMEDIATELY AND DESTROY, ANY DISTRIBUTION OR COPYING OF THIS INFORMATION IS PROHIBITED.**