



## Peer-to-Peer (P2P) Review Request Form

Use this form to:

Request a peer-to-peer review (P2P) of a request that was denied for medical necessity or investigational reasons. The P2P process is not for contract exclusions or reimbursement issues. Please contact our Medical Services by phone at 1-801-587-2851 option #3 if you have any questions.

### Fax completed form to 801-213-1358

- Submitting this form does not guarantee a P2P
- This form must be submitted within 7 calendar days of the date on the denial letter.
- A P2P request will not be accepted if an appeal is on file for the same service.
- If the answers to all the questions below are yes, a P2P may be conducted.
- If the request does not meet these criteria and you wish to submit an appeal, please refer to the denial letter.
- The first requested time must be at least two business days from the time of submission. This allows us to identify and compile all related information prior to the P2P review.
- Please note that all medication-related calls will be routed to a U of U Health Plans clinical pharmacist. If there are questions that the clinical pharmacist is unable to answer, they will schedule a call with a U of U Health Plan Medical Director.
- Helpful information
  - Medical Services phone#: 1-801-587-2851 option #3
  - Fax: 801-213-1358

Fields marked with an asterisk (\*) are required fields. Failure to complete a required field will stop scheduling of a P2P

1. Is this request for a medical necessity or investigational denial related to a pre-service, concurrent review or post-service request?

\_\_\_ Pre-service Review: requests are prior to provided services.

\_\_\_ Concurrent Review: member is currently admitted to an inpatient facility stay.

\_\_\_ Post Service Review: requests after the service has been rendered.

2. Do you understand the option to appeal a medical necessity denial includes the possibility of a same or similar specialty-matched review of all submitted information?\* Note: P2P requests are not specialty-matched.

Yes

No

3. Do you understand that a P2P is a discussion (not an appeal) about a case to further understand the reason(s) for the denial based on our policies? A P2P is not intended to overturn a denial. \* Note: New information about the service must be submitted as an appeal.

Yes

No

4. Is the provider who will be speaking with our medical director the attending or covering provider who will perform or who ordered the requested service?\*

Yes

No

5. Are you able to meet the schedule availability requirements as outlined below?\*

- Provide at least 2 different 1-hour time periods that are at least 2 hours apart.
- The first requested time must be at least two business days from the time of submission. This allows us to identify and compile all related information prior to the P2P review.
- All requested time periods must be between the hours of:

9:00 a.m. and 5:00 p.m., Monday through Thursday (MT)

9:00 a.m. and 3:00 p.m., Friday (MT)

If either of the provider's availability time periods is during a lunch hour, an office staff person, not an answering service, must answer the phone?

Yes

No

6. Is this the first P2P you have requested for this patient and service?\* Additional P2Ps are ONLY allowed for new/different denial on concurrent reviews (i.e., a request to extend an inpatient hospital stay).

Yes

No

## Provider Information

Please enter your contact information for this P2P request:

Name of individual submitting this form:\*

Office or direct phone number for coordination:\* \_\_\_\_\_

Provider Last name:\* \_\_\_\_\_ Provider First name:\* \_\_\_\_\_

**Provider Acknowledgment:** I acknowledge that the Physician has been notified that a Peer to Peer request is being submitted and the Physician will be ready and able to discuss the case at the time of the call.

Signature of Requesting Physician or individual submitting form\* \_\_\_\_\_

Provider phone number for P2P (pager numbers not accepted): \_\_\_\_\_

Provider availability. Please refer to #5 above for requirements:\*

Provide at least 2 different 1-hour time periods that are at least 2 hours apart.

If we have any questions or a need to reschedule the time periods you indicated, we will contact you using the office phone number provided.

Date #1\* \_\_\_\_\_ Times Available\* \_\_\_\_\_

Date #2\* \_\_\_\_\_ Times Available\* \_\_\_\_\_

Date #3 \_\_\_\_\_ Times Available \_\_\_\_\_

Date#4 \_\_\_\_\_ Time Available \_\_\_\_\_

Time Zone\* \_\_\_\_\_

## Member Information

Member Last name:\* \_\_\_\_\_

Member Middle name:\* \_\_\_\_\_

Member First name:\* \_\_\_\_\_

Member ID number :\* \_\_\_\_\_

Date of birth (mm/dd/yyyy):\* \_\_\_\_\_

State:\* \_\_\_\_\_

Reference number (found on denial letter):\*   H   \_\_\_\_\_

Topic for P2P discussion:\*

CPT® code with brief description, if applicable