UnitedHealthcare Community Plan

Re-Review/Reconsideration
PRIOR AUTHORIZATION REQUEST FORM

Please complete this entire form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
Allow at least 24 hours for review.
(This form is for *re-review* only, not an appeal request or initial requests)

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: _____
Is this patient currently hospitalized? □ Yes □ No

Section B - Physician Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Dispense as Written: □ Yes □ No	
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**
Is this member pregnant? □ Yes □ No	**If yes, what is this member's due date?** _____

Section D – Re-Review Information (additional or missing information that may be pertinent to the decision)

- What is the original denied case number? PA-_____

- Has this request gone through the formal appeal process? □ Yes □ No
(The re-review process is separate from the appeals process. Please see the original denial letter for complete information on how to file an appeal if you wish to do so)

Provide additional information:
(New information that was not provided in original case, answered questions from denial note, labs, etc.)

_____
_____
_____
_____

☐ **Please check if additional chart notes/labs/information are attached for review.**

Physician Signature: _____ **Date:** _____