



**New York Prior Authorization Fax Request Form**  
**Fax: 866-950-4490**  
**Phone: 866-604-3267**

Please complete all fields on the form referring to the list of services that require authorization at UHCCCommunityPlan.com. Submit all relevant clinical data such as progress notes, treatment rendered, tests, lab results, and radiology reports to support the request for services. This will help us process your request without delay. Failure to provide sufficient information will delay your request.

Date: \_\_\_\_\_ Contact person: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ **HIPAA secure fax line?**  Yes  No

Requesting Provider: \_\_\_\_\_ TIN/NPI: \_\_\_\_\_

**Member Information**

Member name: \_\_\_\_\_ Member ID/JD#: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Member pregnant?  Yes  No Related to a motor vehicle accident or work-related injury?  Yes  No  
**Member have other insurance?**  Yes  No **If yes, Medicare**  Part A  Part B  
**Other insurance name and policy #** \_\_\_\_\_

**Type of Request**

Routine  Expedited/Urgent (Request must include a physician's order stating that waiting for a decision under a standard timeframe could endanger the member's life, health, or ability to regain maximum functionality or would cause serious pain.)  
 Inpatient  Outpatient  Home

**Servicing Provider and Facility Information**

Servicing provider: \_\_\_\_\_ TIN/NPI: \_\_\_\_\_  
Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
Date of service: \_\_\_\_\_ In network  Out of network   
Servicing facility: \_\_\_\_\_ TIN/NPI: \_\_\_\_\_  
Address: \_\_\_\_\_ In network  Out of network   
Will out of network provider accept Medicaid/Medicare default rate?  Yes  No

**Clinical Information**

Diagnoses: \_\_\_\_\_ ICD-9 codes: \_\_\_\_\_  
**Required** CPT/HCPCS Code(s): \_\_\_\_\_  
Miscellaneous and/or unlisted codes **description required:** \_\_\_\_\_  
Number of visits: \_\_\_\_\_ Start date: \_\_\_\_\_ End date: \_\_\_\_\_  
Frequency: \_\_\_\_\_ DME Cost: \$ \_\_\_\_\_  
Number of previous visits/service description/CPT/HCPCS codes?: \_\_\_\_\_

**Confidentiality Notice:** The documents in this correspondence may contain confidential health information that is privileged and subject to state and federal privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA). This information is intended for the sole use of the addressee named above. If you are not the intended recipient, you are hereby notified that reading, disseminating, disclosing, distributing, copying, acting upon, or otherwise using the information contained in this correspondence is strictly prohibited. If you received this information in error, please notify UnitedHealthcare to arrange for the return of the documents to us or to verify their destruction.