

**Prior Authorization Fax Request Form**

**Fax: 888-899-1499 / Radiology Fax: 866-899-8061**

**Phone: 866-604-3267 / Radiology Phone: 866-899-8054**



Please use this form to request prior authorization. Visit [UHCCommunityPlan.com](http://UHCCommunityPlan.com) to see the list of services that require prior authorization. Scroll to Prior Authorization and choose the list from the drop down menu for the plan you need. Along with the request form, submit relevant clinical information such as progress notes, treatment rendered, tests, lab results and radiology reports for the services requested. Please use the radiology fax and phone numbers for radiology services that require authorization. Please fill out the form completely so we can process your request without delay.

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

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

Requesting Provider: \_\_\_\_\_

Tax ID number/National Provider Identifier number (TIN/NPI): \_\_\_\_\_

Member Information		
Member Name	Member ID/JD#:	Date of Birth:
Member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Related to a motor vehicle accident or work-related injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Member has other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B	
Other insurance name and policy #		
Type of Request		
<input type="checkbox"/> Routine <input type="checkbox"/> 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 function or would cause them serious pain.)		
<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Home		
Servicing Provider and Facility Information		
Servicing Provider:	TIN/NPI:	
Address:	Fax:	
Date of Service:	<input type="checkbox"/> In network <input type="checkbox"/> Out of network	
Servicing Facility:	TIN/NPI:	
Address:	<input type="checkbox"/> In network <input type="checkbox"/> Out of network	
Will out-of-network provider accept Medicaid/Medicare default rate? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**\*\* AHCCCS Registration ID number: \_\_\_\_\_ All providers/facilities must have an AZ State AHCCCS Registration number to participate.**

Clinical Information		
Diagnoses:	ICD-10 codes:	
<u>Required</u> CPT®/HCPCS code(s):		
Miscellaneous and/or unlisted codes <u>description required</u> :		
Number of Visits:	Start Date:	End Date:
Frequency of durable medical equipment (DME):	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.

CPT® is a registered trademark of the American Medical Association.

Doc#: PCA-1-010025-03132018\_03282018

© 2018 United HealthCare Services, Inc.