Prior Authorization Fax Request Form
Fax: 888-899-1499 / Radiology Fax: 866-899-8061
Phone: 866-604-3267 / Radiology Phone: 866-899-8054

UnitedHealthcare® Community Plan

Please use this form to request prior authorization. Visit **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? ☐ Yes ☐ No	Related to a motor vehicle accident or work-related injury? ☐ Yes ☐ No	
Member has 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 function or would cause them 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	

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

Clinical Information		
Diagnoses:	ICD-10 codes:	
Required CPT®/HCPCS code(s):		
Miscellaneous and/or unlisted codes description required:		
Number of Visits:	Start Date:	End Date:
Frequency of durable medical equipment (DME):	DME Cost: $	
Number of previous visits/service description/CPT/HCPCS codes?:		

Doc#: PCA-1-010025-03132018_03282018