UnitedHealthcare Community Plan

UnitedHealthcare Community Plan CRS - Provider Service Requisition Form (PSR)

THIS FORM IS TO BE COMPLETED BY THE CRS MSIC OR PROVIDER AND FAXED TO UnitedHealthcare Community Plan CRS AT 888-899-1499 or CALL 866-604-3267

Part A

REQUISITION DATE: ____________________________

Member Information (Last Name, First Name, MI):			Presenting Diagnosis:	Requesting CRS Clinic (if different):
Date of Birth:	CRS ID#:	Assigned CRS Clinic:	CRS Enrolled Diagnosis:	Other Insurance (TPL): ______________ Policy #s: ______________

Part B

REFERRING CLINIC

☐ Audiology	☐ Gastroenterology	☐ Ophthalmology	☐ Physical Medicine	☐ Speech Therapy
☐ Cardiac	☐ Genetics	☐ Orthodontia	☐ Physical/Occupational Therapy	☐ Spina Bifida – MM IDT
☐ Cerebral Palsy	☐ Metabolic IDT	☐ Ortho – Amputee	☐ Plastic Surgery	☐ Urology
☐ Craniofacial/Orofacial IDT	☐ Nephrology	☐ Ortho - CP	☐ Psychiatry/Psychology	☐ Wound Clinic
☐ Cystic Fibrosis	☐ Neuro	☐ Ortho - Hand	☐ Pulmonary	☐ Wheelchair Clinic
☐ Dental	☐ Neurofibromatosis	☐ Ortho – Scoliosis	☐ Rheumatology	☐ Other (define):
☐ Dermatology	☐ Neurocutaneous	☐ Ortho Spina Bifida -MM	☐ Sickle Cell/Hematology	
☐ Ear, Nose & Throat	☐ Neurosurgery	☐ Pediatric Clinic	☐ SNHL	
☐ Endocrine	☐ Nutrition	☐ Pediatric Surgery	☐ Spasticity IDT	

INSTRUCTIONS

This authorization validates medical necessity only. Payment for services is dependent upon the member's eligibility at the time services are rendered.

MEMBER ELIGIBILITY MUST BE VERIFIED BEFORE PROVIDING SERVICES

Part C

Type of Request: ☐ Standard ☐ Expedited | ☐ Initial Service Request ☐ Continuing Service Request

MEDICAL REFERRAL / SERVICE TYPE

Part D

Place of Service

☐ Field Clinic
☐ Physician Office
☐ Clinic/Office Visit - Date of Service ____/____/____
☐ Home

Medical / Surgical

Surgery Date ______/__________/________
☐ Outpatient ☐ Inpatient
Admit Date: __________/__________/________

Out of State/Network

☐ Location (city/state): ______________________________
Confirmation of necessity is required for Out of State services:
____

Name of Physician______________________________
Address:______________________________________
Specialty: ______________________AHCCCS ID:___________
On (date):_______/_______/______
Phone: (____) _________________Fax: (_____)________________

Type of Service

Consultation
☐ Specialist ☐ Dental
☐ Medical ☐ Surgical

To confirm diagnosis (list, if applicable):

Medical Diagnostic Testing
☐ ECHO (Location) ________________
Auth not required if echo is completed within a MSIC
☐ Genetic Testing
☐ PET Scan
☐ Metabolic Testing
☐ Other ____________________

Psychological/Neurological testing
☐ Neuropsychological Testing

Home Health Care
☐ Skilled Nursing Visits
☐ Infusion
☐ Other

Rehab/Therapies
☐ PT
☐ OT
☐ SP

DME
☐ Wheelchair
☐ Prosthetics/Orthotics
☐ Hearing Aids
☐ Other: ____________________

Type
☐ Purchase ☐ Rental

BEHAVIORAL HEALTH REFERRAL / SERVICE TYPE REQUESTED

Part E

Place of Service

☐ Acute Inpatient Facility

☐ Residential Treatment Center Level I

☐ Theraputic Group Home (TGH) Level II Group Home -H0018
Admit Date: ________/________/__________

☐ Home Care Training Client (HCTC) – S5109

Type of Service

☐ Non Par Behavioral Health Consultation or Treatment:
Name of Physician/facility Specialty:
____
On (date):________/_______/______
Phone: (____) __________________
Fax: (______)___________________

☐ Neuropsychological Testing

Special Request

☐ Out of State/Network
Location (city/state):________________
Confirmation of necessity is required for Out of State services:
____
____
Name of:
Physician/facility:______________
____
Specialty:
____
On (date):_______/_______/______
Phone: (____)

Prior Authorization **MUST** be Obtained Prior to Rendering of non-Emergency Services. Please Attach Any Pertinent Chart Notes, Lab/X-Ray Reports With PSR request.

Part F **REFERRING/REQUESTING PHYSICIAN/PROVIDER INFORMATION** ☐ CRS CLINIC ☐ Physician Office Visit

REQUESTING PHYSICIAN NAME (FIRST AND LAST NAME)	SPECIALTY	PHONE NUMBER
ADDRESS of REQUESTING PHYSICIAN		
CONTACT PERSON (FIRST AND LAST NAME)	CONTACT PERSON TITLE	FAX NUMBER

Part G **SERVICING PROVIDER INFORMATION (All requests must be for the same billing #)** ☐ In CRS CLINIC ☐ Outside of CRS CLINIC

(PHYSICIAN, AGENCY, PROVIDER) NAME:	SPECIALTY		PHONE NUMBER
ADDRESS (N O., STREET, CITY, STATE, ZIP)	TIN #	AHCCCS ID #	FAX NUMBER

Part H **SERVICING FACILITY INFORMATION (All requests must be for the same billing #)** ☐ In CRS CLINIC ☐ Outside of CRS CLINIC

(FACILITY) NAME:	DATE OF PROCEDURE		PHONE NUMBER
ADDRESS (N O., STREET, CITY, STATE, ZIP)	TIN #	AHCCCS ID #	FAX NUMBER

Part I **PROCEDURE/SERVICE INFORMATION**

REQUESTED SERVICE	CPT / HCPS CODE	# UNITS	FREQUENCY	FROM	TO	REASON FOR SERVICE

UnitedHealthcare Community Plan Children's Rehabilitative Services

Purpose of the Provider Service Requisition (PSR) Form

The purpose of this form is to provide any physician with a designated form to request services in sufficient scope and duration to meet the medical needs of a CRS enrolled diagnosis. Referring physicians will use this form for elective CRS referrals that require obtaining prior authorization from the Intake Prior Authorization Unit. The form is not used for requesting services at the MSIC.

Valid Authorizations

Authorizations are valid only if the CRS member is enrolled with UnitedHealthcare Community Plan CRS on each date of service. Services must be provided within three days prior to or after the date(s) of service authorized. Generally, authorizations are valid for 90 calendar days from the date of request and for a designated number of units/visits. Please call to verify the prior authorization number and date(s) of service authorized.

Part A

1. Enter date form is completed
2. Enter member's last name first and first name
3. Enter member's date of birth
4. Enter CRS ID#
5. Enter Name of Assigned Clinic Site
6. Enter Name of Requesting Clinic Site, if different
7. Enter Member's presenting diagnosis as the basis for the procedure/services requested
8. Enter Member's enrolling CRS diagnosis that is relevant to this specific authorization
9. Identify any third party liability coverage
    i. Enter other insurance carrier's name
    ii. List other insurance policy number, if available

Part B

1. Completed by the MSIC clinic only: Select specialty clinic requesting service
2. If specialty clinic is not listed, select "Other": and define clinic by name

Part C Enter type of request, Expedited or Standard

1.
    a. Expedited is indicated or determined by the provider or UnitedHealthcare Community Plan CRS medical director that serious jeopardy of the member's life, health or ability to maintain or regain maximum function may result if the request is processed using standard timeframes (14 calendar days).
    b. Select "Initial Service Request" for first or separate request for this service or "Continuing Service" if the request is for an additional request for services that are currently being provided.

Part D

1. Place of Service – Select place where service will be performed
    a. Indicate date of Office Visit, if appropriate b.
    Indicate date of Surgery, if appropriate
    c. Indicate date of Admission, if appropriate
    d. Indicate City and State of facility for out of state admission
        i. Confirmation with physician of same specialty in another region is required for all Out of State requests
        ii. Enter Physician Name
        iii. Specialty
        iv. Date of conversation
        v. Phone number of consulted physician
2. Type of Service – Select appropriate category of service being requested
    a. Select specialty clinic requesting service
    b. DME- select type and if purchase or rental.

Part E

1. Behavioral Health- Place of Service – Select place where service will be performed
    a. Indicate date of Office Visit, if appropriate
    b. Indicate date of Admission, if appropriate
    c. Indicate City and State of facility for out of state admission
    d. Neuropsychological Testing
    e. Level I, II, III Behavioral Health facility
        I. Confirmation with physician of same specialty in another region is required for all Out of State requests
        II. Enter Physician Name
        III. Specialty
        IV. Date of conversation
        V. Phone number of consulted physician

Part F

1. Select whether this request was the result of a visit in the CRS Clinic or a physician office visit
2. Enter the name and specialty of the physician who wrote the order for the request
3. Enter the contact information for the person completing the form (First and Last Name, Phone and Fax numbers). This should be the name and number of the individual who can answer questions concerning the request and the fax number where the response is to be forwarded to.

Part G & Part H

1. Enter the Name, Address, Phone, Fax, Tax Id. (TIN #) and AHCCCS ID for the Provider or Facility providing and being paid for the services
   Examples:
   a. Name of Therapist in a CRS Clinic for a PT, OT or ST request along with the CRS Clinic address, phone and fax information
   b. Physician, specialty, office information for requests for an Office Visit
   c. IP or OP facility information for procedures, surgeries or diagnostic tests requiring
   d. DME, Orthotic or Prosthetic company info for requests for Wheelchairs or other equipment
   e. Home Health Company for nursing visits or infusion services

Part I

1. Enter description of requested service
2. Enter CPT/HCPS Codes for requested services
3. Enter #of Units/Visits
4. Enter frequency of services, if applicable
5. Enter dates of service
6. Enter reason for service