



**LONG TERM CARE  
PRIOR AUTHORIZATION FAX REQUEST FORM**

**Fax: 800-278-2907**

**Phone: 800-377-2055 or 602-255-8188**

Please complete all fields on the form referring to the list of services that require authorization at UHCCommunityPlan.com. Be sure to submit all relevant clinical data such as progress notes, treatment rendered, tests, lab results, and radiology reports to support the request for services to avoid processing delays.

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

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

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

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 functionality or would cause serious pain.)  
 **Inpatient**  **Outpatient**  **Home**

**Servicing Provider and Facility Information**

Servicing provider: \_\_\_\_\_ TIN/NPI: \_\_\_\_\_  
Address: \_\_\_\_\_ Fax: \_\_\_\_\_  **In-network**  
Date of service: \_\_\_\_\_  **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-10 Codes: \_\_\_\_\_  
**Required CPT/HCPCS Code(s):** \_\_\_\_\_  
Miscellaneous and/or unlisted codes **description required:** \_\_\_\_\_  
Number of visits/units: \_\_\_\_\_ Start date: \_\_\_\_\_ End date: \_\_\_\_\_  
Frequency: \_\_\_\_\_ DME Cost: \$ \_\_\_\_\_  
Number of previous visits/service description/CPT/HCPCS codes: \_\_\_\_\_

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