UnitedHealthcare Community Plan

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**
M**ember 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: _____