UnitedHealthcare Community Plan

Prior Authorization Form

Fax completed form to: 866-607-5975

If you have a prior authorization request, please complete all fields on this form for services that require prior authorization and fax the completed form to **866-607-5975.** A complete list of services that require authorization is available at **UHCCommunityPlan.com** > For Health Care Professionals > Florida > Provider Information. To help us process your request as quickly as possible, please submit supporting clinical data such as progress notes, treatment rendered, tests, lab results, and radiology reports. If you have questions, please call Provider Services at **866-604-3267.** Thank you.

Date:_____Contact person:_____Phone: _____

Fax:_____**HIPAA secure fax line?** □ Yes □ No

Requesting care provider:_____TIN/NPI: _____

Member Information

Member name:_____Member ID#:_____Date of birth: _____

Member pregnant? □ Yes □ No Related to a motor vehicle accident or work-related injury**?** □ Yes □ No

Member have 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 health

Servicing Care Provider and Facility Information

Servicing care 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 care 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:_____Start date:_____End date: _____

Frequency:_____Durable medical equipment cost: $_____

Number of previous visits/service description/CPT/HCPCS codes:

_____

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