

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 UHCommunityPlan.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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