UnitedHealthcare Community Plan

Prior Authorization Fax Request
Form Fax: 888-840-9284
Phone: 866-604-3267

Please complete all fields on the form referring to the list of services that require prior authorization at UHCCommunityPlan.com > Notifications/Prior Authorizations. Submit all relevant clinical data such as progress notes, treatment rendered, tests, lab results and radiology reports to support the request for services. If you do not provide sufficient information, your request may be delayed.

Date:_____ Contact person: _____ Phone: _____

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

Requesting Provider:_____ TIN/NPI: _____

Member Information

Member name:_____ Member ID/JD#:_____ Date of birth: _____
Is the member pregnant? □ Yes □ No
Is this related to a motor vehicle accident or work-related injury? □ Yes □ No
Does the 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, ability to regain maximum functionality or would cause serious pain).
□ Inpatient □ Outpatient □ Home

Servicing Provider and Facility Information

Servicing provider:_____ TIN/NPI:_____
Address: _____ Fax:_____
Date of service: _____ □ Network □ Out-of-network
Servicing facility:_____ TIN/NPI:_____
Address:_____ □ 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:_____ Start date:_____ End date: _____
Frequency:_____ Durable medical equipment cost: $_____
Number of previous visits/service description/CPT/HCPCS codes: _____

If you have questions, please contact the Intake Department at 866-604-3267.