



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.

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