UnitedHealthcare Community Plan

New York Prior Authorization Fax Request Form
Fax: 866-950-4490
Phone: 866-604-3267

Please complete all fields on the form referring to the list of services that require authorization at UHCCommunityPlan.com. Submit all relevant clinical data such as progress notes, treatment rendered, tests, lab results, and radiology reports to support the request for services. This will help us process your request without delay. Failure to provide sufficient information will delay your request.

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

Servicing Provider and Facility Information

Servicing 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 provider accept Medicaid/Medicare default rate? □ Yes □ No

Clinical Information

Diagnoses: _____ ICD-9 codes: _____
Required CPT/HCPCS Code(s): _____
Miscellaneous and/or unlisted codes **description required**: _____
Number of visits: _____ Start date:_____ End date: _____
Frequency: _____DME Cost: $_____
Number of previous visits/service description/CPT/HCPCS codes?: _____
_____

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