UnitedHealthcare Community Plan

LONG TERM CARE THERAPY PRIOR AUTHORIZATION REQUEST

Phone 1 (800) 377-2055 OR 1 (602) 255-8188 **Fax 1 (800) 278-2907**

To: ______________________ Fax: ______________________

Member's Name: ______________________ ID # ______________________

Ordering Physician: ______________________

Physician Phone: ______________________ Fax: ______________________

DX Description: ______________________ DX Code: ______________ Onset Date: ______________

☐ Routine (14 days) ☐ Urgent (3 business days) This means using the standard (routine) timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

Please include a copy of the initial evaluation, clinical notes and physician orders

☐ Physical ☐ Occupational ☐ Speech

Requested sessions: ______________ Total of days per week: ______________ Number of weeks: ______________

Date of service for requested auth: ______________ to ______________

CPT Code: ______________________ # of units per session: ______________

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Comments: ____

Therapists Name: ______________________ Facility: ______________________

Phone Number: ______________________ Fax Number: ______________________

Facility / Provider ID Number: ______________________

THIS SECTION FOR UHCCP LTC USE ONLY

Date: **Comments:**

Authorization: ☐ Approved ☐ Denied ☐ Duplicate Request Entered ______________ Date ______________

☐ COB Required – UHCCP LTC is not primary and will not pay balance of allowable without EOB from primary carrier

☐ Benefit does not require prior authorization by Utilization Management

Authorization Staff Signature ______________________ Date ______________