

When you need to request prior authorization, please use this form and complete all fields. The list of services that require authorization are available at **UHCommunityPlan.com** > For Health Care Professionals > California > Provider Information.

Along with this form, please fax 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 review your request without delay. If you have questions, please call us at **800-366-7304**.

Date: _____ Contact person: _____ Phone: _____

Fax number: _____ Is this a **HIPAA secure fax line?** Yes No

Requesting provider name: _____

Tax ID Number (TIN) /National Provider Identifier (NPI) number: _____

Member Information

Member name: _____ Member ID/JD#: _____ Date of birth: _____

Is the member pregnant? Yes No

Is the request 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

If member has other insurance, list the 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 name: _____ TIN /NPI number: _____

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-10 codes: _____

Required CPT/HCPCS code(s): _____

Miscellaneous and/or unlisted codes description required: _____

Number of visits: _____ Start date: _____ End date: _____

Frequency of Durable Medical Equipment (DME) Use: _____ DME cost: \$ _____

Please list the number of previous visits/service description/CPT/HCPCS codes: _____

Confidentiality Notice: The documents in this correspondence may contain confidential health information that is privileged and subject to state and federal privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA). This information is intended for the sole use of the addressee named above. If you are not the intended recipient, you are hereby notified that reading, disseminating, disclosing, distributing, copying, acting upon, or otherwise using the information contained in this correspondence is strictly prohibited. If you received this information in error, please notify UnitedHealthcare to arrange for the return of the documents to us or to verify their destruction.