UnitedHealthcare Community Plan

Prior Authorization Fax Request
Form Fax: 855-432-2828
Phone: **800-366-7304**

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 **UHCCommunityPlan.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: _____
_____

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