

Prior Authorization Request Form for Acute Medical Services

Please complete all necessary fields on the form for services requiring prior authorization. To see the list of services, please go to UHCCommunityPlan.com > Health Professionals > Iowa > Prior Authorization List. 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.

Requester Information

Date: _____ Contact name: _____ Phone #: _____
 Fax #: _____ Is this number a **HIPAA-secure fax line?** Yes No
 Requesting care provider name: _____ TIN/NPI #: _____

Member Information

Member name: _____ Member ID card #: _____ Date of birth: _____
 Is 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**, check Medicare Part A Part B
 Name of other insurer: _____ Other insurance policy # _____

Type of Request

Routine Expedited/Urgent (Expedited requests must include a physician's order stating that waiting for a standard timeframe decision could endanger the member's life, health, or ability to regain maximum functionality or would cause serious pain.)
 Inpatient Outpatient Home

Servicing Provider or Facility Information

Servicing care provider name: _____ TIN/NPI #: _____
 Address: _____ Fax #: _____
 Date of service: _____ In network Out of network
 Servicing facility name: _____ TIN/NPI #: _____
 Address: _____ In network Out of network
 If considered an out-of-network care provider, will the Iowa Medicaid Provider Reimbursement Rate Floor be accepted? 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: _____
 If this is for durable medical equipment (DME), is the cost more than \$500? Yes No
 How often do you bill for DME services? (please list, for example, daily, weekly or monthly) _____
 Number of previous visits/service description/CPT/HCPCS codes?: _____
 Notes: _____

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.