UnitedHealthcare Community Plan | ia health link

Fax completed form: **888-899-1680**
Request by phone: **888-650-3462**

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: _____

Doc #: PCA-1-009519-01292018_02152018