

**Nebraska Prior Authorization Fax Request Form**

Please complete all fields on the form for any service requiring authorization. Submitting all relevant clinical data such as progress notes, treatment rendered, tests, lab results, and radiology reports will help us process your request without delay. Failure to provide sufficient information may delay your request.

A complete list of services requiring prior authorization can be found at [UHCCommunityPlan.com](http://UHCCommunityPlan.com) > For Health Care Professionals > Nebraska > Prior Authorization & Notification.

Date: \_\_\_\_\_ Contact person: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ **HIPAA secure fax line?**  Yes  No

Requesting care provider: \_\_\_\_\_ TIN/NPI: \_\_\_\_\_

**Member Information**

Member name: \_\_\_\_\_ Member ID/JD#: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Member's preferred phone number: (\_\_\_\_) \_\_\_\_\_ Is the member pregnant?  Yes  No

Related to a motor vehicle accident or work-related injury?  Yes  No

**Does member have other insurance?**  Yes  No **If yes, Medicare**  Part A  Part B

**Other insurance 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  Private duty nursing

**Servicing Care Provider and Facility Information**

Servicing care provider: \_\_\_\_\_ TIN/NPI: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Date of service: \_\_\_\_\_ In network  Out of network

Servicing facility: \_\_\_\_\_ TIN/NPI: \_\_\_\_\_

Address: \_\_\_\_\_ In network  Out of network

Will out of network care provider accept Medicaid/Medicare default rate?  Yes  No

**Clinical Information**

Diagnoses: \_\_\_\_\_ ICD-10 codes: \_\_\_\_\_

**Required:** CPT/HCPCS Code(s): \_\_\_\_\_

**Description required:** Miscellaneous and/or unlisted codes: \_\_\_\_\_

For codes S9122, S9123 and S9124, please provide the requested number of units per day \_\_\_\_\_

Number of visits: \_\_\_\_\_ Start date: \_\_\_\_\_ End date: \_\_\_\_\_

Frequency: \_\_\_\_\_ Durable medical equipment cost: \$ \_\_\_\_\_

Number of previous visits/service description/CPT/HCPCS codes: \_\_\_\_\_

**Please fax your completed form to 866-622-1428.**

**If you have questions, please call 866-604-3267.**

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