UnitedHealthcare Community Plan

Pennsylvania 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** > For Health Care Professionals > Pennsylvania > 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

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Clinical Information

Diagnoses: _____

ICD-10 codes: _____

Required: CPT/HCPCS Code(s): _____

Description required: Miscellaneous and/or unlisted codes: _____

For codes T1000, 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 877-310-3826.

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