UnitedHealthcare®
Community Plan

TennCare/SNP Prior Authorization & Concurrent Review for Behavioral Health*

Date: ______________________ **From:** ____

Contact Name: ______________ **Telephone #:** _____________ **Fax #:** ______________

Type of Review: ☐ **Prior Authorization** ☐ **Concurrent**

Type of Service: (circle)

Psychiatric Inpatient	24-Hour PRTF	Partial Hospitalization (MH)	Intensive Outpatient (MH)
Enhanced Supported Housing	Supported Housing	Psychological Testing	Neuropsychological Testing
ECT	ACT/PACT	CTT	CCFT
Inpatient Detox (SA)	Residential Detox (SA)	Residential Rehabilitation (SA)	Partial Hospitalization (SA)
Intensive Outpatient (SA)	Nursing Home Plus	ABA	

Physician/Health Care Professional Information:

Date(s)/Units of Service Requested: ____________ **Date this service is expected to end**[+]**:** ___________

Attending Physician/APN: _______________________ **Phone #:** ______________________

Address: __________________________________ **Fax #:** ________________________

Facility: __________________________________ **PAR or Non-PAR**

Member Information:

Member Name: _____________________ **Mbr SS#:** _____________ **Mbr DOB:** __________

Does member have other insurance? ☐ **Yes** ☐ **No**

If yes, other insurance name: ____

Clinical Information:

Diagnoses: ____

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Goals of Service: ____

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Please submit any pertinent clinical data (i.e. assessments/screenings, treatment plan/service plan, WRAP, progress notes, treatment plan summaries) to support request for services.

[+] **It is understood that the expected service end date is based on clinical information available to the provider at the time of the request, and is subject to change.**

Fax Numbers: East Providers (1-877-614-7141), Middle Providers (1-888-785-1434), West Providers (1-866-359-3770)