UnitedHealthcare Community Plan

Personal Care Work Services (PCW)

Prior Authorization Fax Form

Please complete all fields on the form and fax to: 866-273-2240

SECTION I — PROVIDER INFORMATION

1. Check request type ☐ Initial request ☐ Re-certification request	2. Process Type ☐ Routine ☐ Urgent ***(urgent is defined as "significant impact to health of the member")***	3. Telephone/Fax Number — Billing Provider Phone: Fax:
4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)		5a. Billing Provider Tax ID Number (TIN) 5b. Billing Provider Taxonomy Code (if available)
6a. Name — Prescribing / Referring / Ordering Provider		6b. National Provider Identifier — Prescribing / Referring / Ordering Provider

SECTION II — MEMBER INFORMATION

7. Member Identification Number	8. Date of Birth — Member	9. Address — Member (Street, City, State, ZIP Code)
10. Name — Member (Last, First, Middle Initial)	11. Gender — Member ☐ Male ☐ Female	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

12. Diagnosis — Primary Code and Description	13. Start Date — SOI	14. First Date of Treatment — SOI
15. Diagnosis — Secondary Code and Description	16. Requested PA Start Date	

17. Rendering Provider Number	18. Rendering Provider Taxonomy Code	19. Service Code	20. Modifiers 1	2	3	4	21. POS	22. Description of Service	23. QR	24. Charge
		T1019					12			
		T1019	U3				12			
		99509					12			

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. In order to process your request completely and timely, submit any pertinent clinical data (i.e. progress notes, treatment rendered, tests, to support request for services. Any request for OON services must include documentation on the reason for the request along with the name of the OON provider. **FAILURE TO PROVIDE SUFFICIENT INFORMATION WILL RESULT IN A DELAY IN YOUR REQUEST**.

25. Total Charges

26. **SIGNATURE** — Requesting Provider

27. Date Signed