UnitedHealthcare Community Plan

United Healthcare Community Plan Prior Authorization Request Form

Phone: 1-888-980-8728

Fax to: 1-800-267-8328

Today's Date: ____________ **URGENT:** ☐ Yes ☐ No

MEMBER INFORMATION

Please Print

Patient Name: ____________ Member ID#: ____________

Other Health Ins: ____________ ☐ Male ☐ Female DOB: ____________

Home Address: ____________

City, State and ZIP Code: ____________ Phone: ____________

REFERRING PHYSICIAN INFORMATION

Physician's Name: ____________ Specialty: ____________

Contact Name: ____________ Phone #: ____________

Physician / Authorized Signature: ____________ Fax #: ____________

SERVICING PROVIDER INFORMATION

TIN ____________ PAR/NON PAR ____________

Does the NON PAR provider accept HI Medicaid rates? ☐ YES ☐ NO

Provider's Name: ____________ Specialty: ____________

Provider's Address: ____________ Phone #: ____________

Office Contact Name: ____________ Fax #: ____________

Service Setting (IP, OP, Office, other): ____________ Facility Name: ____________

Date of Service: From: ____________ To: ____________ OR ☐ Pending Authorization

PT / OT / Speech Therapy: ☐ Initial Request **or** ☐ Continuing: Last DOS: ____________ PLEASE SPECIFY # of Visits: ____________

☐ Requests for **continuation** of PT / OT / ST: Send initial and / or updated evaluation and progress notes along with physician's signature.

Reason for Request:

Please attach clinical notes / documentation of medical necessity for requested service:

*ICD-9 CODE(S)	**ICD-10 CODE(S)	*ICD-9 Codes are required for Date(s) of Service prior to 10/1/2015; **ICD-10 Codes are required for Date(s) of Service on/after 10/1/2015 Please do not use ICD-10: R69, ILLNESS UNSPECIFIED, as it is not an authorized code ENTER DIAGNOSIS DESCRIPTION (Below)

CPT / HCPC CODE(S)	COST OF DME	PROCEDURE(S) / TREATMENT(S)	# OF VISIT(S) or UNIT(S) AND FREQUENCY (PER DAY, MONTH, OR YEAR)

Durable Medical Equipment (DME): ☐ Rental or ☐ Purchase (Must include MD's order and medical documents with DME cost)

Transportation required: ☐ Yes ☐ No

If Air transportation is being requested, please submit the AIR TRANSPORTATION REQUEST FORM together with this Prior Authorization request for Medical Services. Please submit routine transportation requests 14 days prior to the travel date.

Once approved, this notification in valid for the number of authorized visit(s), date(s) that are approved for the condition and only for the patient identified. NOTE: Coverage is dependent on member's eligibility and plan benefit at the time of service. Prior Notification Form (Rev. 1/19).