Michigan Prior Authorization Fax Request Form

Please complete all fields on the form. Submit all relevant clinical data such as progress notes, treatment rendered, tests, lab results, and radiology reports to support the request for services. This will help us process your request without delay. Failure to provide sufficient information will delay your request. Refer to the list of services that require authorization at UHCprovider.com. Please fax the completed form to us at **855-225-9847**. If you have questions, please call us at **800-903-5253.**

Date: __________ Contact person: _______________________ Phone: _____________________

Fax: ______________________________ HIPAA secure fax line? ☐ Yes ☐ No

Requesting Provider: ______________________________ TIN/NPI: _____________________

Member Information

Member name: ________________________________ Member ID/JD#:__________________

Member date of birth: _______________ Member pregnant? ☐ Yes ☐ No

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

Member have other insurance? ☐ Yes ☐ No If yes, Medicare ☐ Part A ☐ Part B

Other insurance name and policy #____

Type of Request

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.

☐ Routine ☐ Expedited/Urgent

☐ Inpatient ☐ Outpatient ☐ Home

Servicing Provider and Facility Information

Servicing 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 provider accept Medicaid/Medicare default rate? ☐ Yes ☐ No

Clinical Information

Diagnoses: _____________________ ICD-9 codes: ____

Required CPT/HCPCS Code(s): ____

Miscellaneous and/or unlisted codes description required: ________________________________

Number of visits: ____________ Start date:____________ End date: _______________________

Frequency: ____________________DME Cost: $_________

Number of previous visits/service description/CPT/HCPCS codes?: ________________________

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