UnitedHealthcare Community Plan of Hawaii Prior Authorization Request form

Urgent: ☐ Yes ☐ No Today's date ______________________ Phone: 888-980-8728 Fax to 800-267-8328

Member information

Name (Last, First, Middle):				Gender ☐M ☐F	DOB:
Home street address (Do not enter P.O. Box):					Phone:
City:	State:	ZIP code:	Member ID#:		Other Health Insurance:

Referring physician information

Physician's name:	Specialty:
Contact name:	Phone:
Physician/authorized signature:	Fax:

Servicing provider information

Provider's name:	Specialty:	
Provider's address:	Phone number:	
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:
Reason for request:		
☐ Clinical notes/documentation of medical necessity for requested service attached		

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

CPT®/HCPCS 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 ☐ Purchase (Must include MD's order and medical documents with DME cost)
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.
Transportation required: ☐ Yes ☐ No

Once approved, this notification is 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. 4/21).

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