

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 Pr	ovider:	TIN/NPI:	<u></u>
Member Infor	mation		
Member name	e:	Member ID/JD#:	
Related to a m	notor vehicle accident o	Member pregnant? □ Yes □ No r work-related injury? □ Yes □ No s □ No If yes, Medicare □ Part A □ Part B	
Type of Request Request must endanger the Example Contine Example Contine Cont	est include a physician's o	rder stating that waiting for a decision under a standar ability to regain maximum functionality or would car	
_	_	TIN/NPI:	
Address:		Fax:	
Date of service	e:	In network □ Out of network □	
Servicing facility:		TIN/NPI:	
	work provider accept M	In network □ Out of network □ ledicaid/Medicare default rate? □ Yes □ No	1
Diagnoses:		ICD-9 codes:	
Required CPT	/HCPCS Code(s):		
Miscellaneous	and/or unlisted codes	description required:	
Number of visi	its: Start	date: End date:	
Frequency:	D	ME Cost: \$	
Number of pre	evious visits/service des	scription/CPT/HCPCS codes?:	

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