# Prior authorization request form

## Overview

Please complete this form to request prior authorization. For a list of services that require authorization, visit **UHCprovider.com/mocommunityplan** > Prior Authorization and Notification. If you have questions, please call us at **800-366-7304**.

Date:

Contact person: Phone:

Requesting care provider name:

Tax ID number (TIN) / National Provider Identifier (NPI) number:

## Member Information

Member name: Member ID/JD #:

Date of birth:

Is the member pregnant? ☐ Yes ☐ No

Is the request related to a motor vehicle accident or work related injury? ☐ Yes ☐ No

Does the member have other insurance? ☐ Yes ☐ No If yes, Medicare ☐ Part A ☐ Part B

If member has other insurance, list the name and policy #:

## Type of request

☐ Inpatient ☐ Outpatient ☐ Home ☐ Routine ☐ Expedited/Urgent

For urgent requests, please include a physician's order stating that waiting for a decision under a standardtime frame could endanger the member's life, health or ability to regain maximum functionality or wouldcause serious pain.




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# Servicing provider and facility information

| | |
|---|---|
| Servicing provider name: | TIN/NPI number: |
| Address: | Fax: |
| Date of service: | ☐ Network ☐ Out of network |
| Service facility: | TIN/NPI: |
| Address: | ☐ Network ☐ Out of network |

☐ Will out-of-network provider accept Medicaid/Medicare default rate? ☐ Yes ☐ No

# Clinical information

| | | |
|---|---|---|
| Diagnosis: | ICD-10 codes: | |
| Required CPT®/HCPCS code(s): | | |
| Miscellaneous and/or unlisted codes description required: | | |
| Number of visits: | Start date: | End date: |
| Frequency of durable medical equipment (DME) use: | DME cost: $ | |
| Please list the number of previous visits/service description/CPT/HCPCS codes: | | |

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