UnitedHealthcare
Community Plan

New Jersey Long Term Care prior authorization fax request form

fax to:

855-583-4041 or 855-489-1553

Date:	Member name:
Member date of birth:	**If applicable, caregiver or contact name:**
Member ID:	**Member phone #:**
Member address:	**Diagnosis:**
Requesting provider:	**Signature stamp:**

SERVICE REQUESTED/CODE (circle) (hours/day/week): **FREQUENCY**

Service	Frequency
Managed Long Term Services and Support (MLTSS) Private Duty Nursing (PDN) services (T1000)	___________# hours per day ________# days/week
MLTSS PDN services (T1002)	___________# hours per day ________# days/week
MLTSS PDN services (T1003)	___________# hours per day ________# days/week
Adult medical day care (S5102)	___________# hours per day ________# days/week
Pediatric medical day care (T1024)	___________# hours per day ________# days/week
Adult personal care services (T1019)	___________# hours per day ________# days/week *If group hours, please provide information for other member: Name_______________________ UnitedHealthcare ID #____________

****PDN team will contact provider for required documentation****

PURPOSE OF SERVICE REQUESTED:

Purpose	Response
For NEW services?	**Yes ☐ No ☐**
For ADDITIONAL (increased) services?	**Yes ☐ No ☐**
For REAUTHORIZATION of services?	**Yes ☐ No ☐**
A member APPROVED provider transfer?	**Yes ☐ No ☐**
To CONTINUE services approved by another managed care organization (MCO) for a member who has or will switch to an MCO?	**Yes ☐ No ☐** MCO name: ______________________________

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SERVICES CURRENTLY IN PLACE:	FREQUENCY (hours/day/week)
MLTSS PDN services (T1000)	____________# hours per day _________# days/week
MLTSS PDN services (T1002)	____________# hours per day _________# days/week
MLTSS PDN services (T1003)	____________# hours per day _________# days/week
Adult medical day care (S5102)	____________# hours per day _________# days/week
Pediatric medical day care (T1024)	____________# hours per day _________# days/week
Adult personal care services (T1019)	____________# hours per day _________# days/week *If group hours, please provide information for other member: Name_________________________ UnitedHealthcare ID #_______________

If servicing provider is already in place or a specific provider is requested, please fill out the information below:

Servicing provider:	Servicing provider contact name:
Servicing provider ID #:	Servicing provider TIN and NPI #:
Servicing provider address:	Servicing provider phone #: Servicing provider fax #:

For MLTSS PDN: T1000, T1002, and T1003 requests, please provide information below:

Requesting provider:	Requesting provider contact name:
Requesting provider ID #:	Requesting provider TIN and NPI #:
Requesting provider address:	Requesting provider phone #: Requesting provider fax #:

Additional comments:

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If your request is for new MLTSS services, do not use this form. The MLTSS member should call their care manager at **800-262-0305** 9 a.m. – 8 p.m. ET, Monday – Friday.

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