UnitedHealthcare

Pre-Determination of Benefits Form

For Commercial Members Only

Fax completed form to: 866-756-9733

Note: To avoid delay in processing your request, please fill out this form completely.

PHYSICIAN OR OTHER HEALTH CARE PROVIDER

Physician or Provider Name _____

Physician or Provider Tax ID _____

Address _____

Name of Facility _____

Facility Address _____

Anticipated Date of Service _____ / _____ / _____ ☐ Inpatient ☐ Outpatient

PATIENT INFORMATION

Subscriber Name _____

Subscriber Number _____

Patient Name _____

Patient Date of Birth _____ / _____ / _____

Group/Policy Number _____

SERVICE DESCRIPTION

Diagnosis Codes		CPT/HCPCS	
1.		1.	5.
2.		2.	6
3.		3.	7.
4.		4.	8.

Comments/Notes Describing the Service:

_____

_____

_____

ADDITIONAL INFORMATION

Note: Please fax any documentation that will clarify your request with this form. Examples include:

- Test Results (lab, visual fields, radiology, sleep study, etc.)
- Patient's Current Condition (height, weight, etc.)
- Pertinent History/Evaluation
- Progress Notes