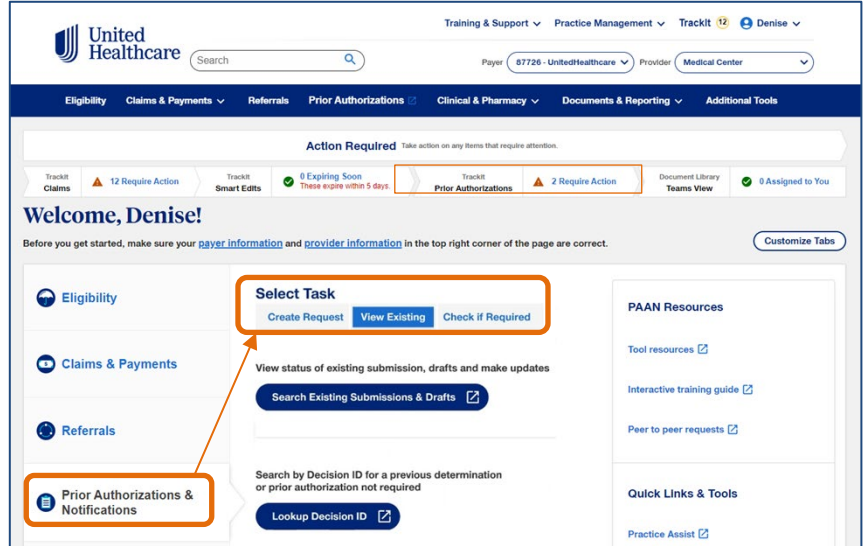




Check prior authorization status, submit new medical prior authorizations and inpatient admission notifications, submit case updates such as uploading required clinical documentation, and more.

1. Sign in at UHCprovider.com
 - If not yet registered, consult UHCprovider.com/access
2. Select **Prior Authorizations & Notifications** from the Provider Portal
(Note: You can see prior authorizations that need attention in the **TrackIt Action Required** bar near the top of the screen)
3. Select the appropriate task
 - **Create Request**
 - **View Existing**
 - You may **View Status** or **Make Updates**
 - **Check if Required**
(Note: For **Inquiries**, please consult the [interactive guide](#))



SEARCH RESULTS Showing 1 to 2 of 2 View per page 10 < 1 of 1 >

ROW#	NOTIFICATION AUTHORIZATION #	MEMBER ID	LAST NAME	FIRST NAME	SERVICE SETTING	PLACE OF SERVICE	SERVICE DATES	CASE STATUS
1	A010000005	88888888	PATIENT	NATHAN	Inpatient	Acute Hospital	06/30/2017-07/01/2017	Click here for more details
2	A010000001	99999999	PATIENT	MARIE	Outpatient Facility	Outpatient Facility	06/23/2017-06/23/2017	Click here for more details

View Existing Submissions

After choosing a search method, entering the criteria and searching:

- A. Select the appropriate **Notification/Authorization #**
- B. Review
 - **Case Details**
 - **Coverage Status** of each procedure
 - **Current attachments**
 - **Service Details**, and more

CASE DETAILS

NOTIFICATION/PRIOR AUTHORIZATION NUMBER	CASE STATUS	CASE STATUS REASON	PRIMARY CARE PHYSICIAN
A010000005	Anticipated Admission	Complete Awaiting Admission	My Doctor
ADVANCE NOTIFY DATETIME	ADMISSION NOTIFY DATETIME	EXPECTED DATES OF SERVICE	ACTUAL DATES OF SERVICE
06/24/2017 10:48 PM CDT	-	08/01/2017 - 08/05/2017	-

COVERAGE STATUS

I-3	CODE	DESCRIPTION	COVERAGE STATUS	DECISION DATE
1	43633	Gastrectomy, partial, distal, with Roux-Y more	Pending	
2	43865	Revision of gastrojejunal anastomosis by more	Pending	

Update an Existing Submission

- A. Revise select fields on the form
- B. **Select Files** to attach additional documents
- C. **Update** once complete

ATTACH CLINICAL DOCUMENTATION

DATE	FILE NAME	STATUS
07/15/2017	Update Service Dates.docx	Additional Clinical

[Select Files](#)

Maximum file size for upload: 25MB, per file. Acceptable file types: bmp, doc, docx, gif, jpg, jpeg, pdf, png, tiff, txt

[Back To Top](#) [UPDATE](#)



FACILITY DETAILS

NAME*	ADDRESS*
CHILDRENS HOSP	220 Doctors Ln, Somecity, USA
FACILITY ID NUMBER*	STATUS
97797977	In-Network

ADMITTING/ATTENDING PHYSICIAN DETAILS

NAME	ADDRESS
	Select Provider*

SERVICE DETAILS

PLACE OF SERVICE* **Acute Hospital** SERVICE DETAILS* **Medical**

FACILITY SERVICE DATES DETAILS

Has Patient been admitted or will they be admitted today? YES NO

ADMISSION DATE* SERVICE DESCRIPTION* **Emergency**

DIAGNOSIS DETAILS

CODE	DESCRIPTION
New	Delete

[Add another diagnosis code](#)

PROCEDURE DETAILS

CODE	DESCRIPTION	SERVICING PROVIDER NAME, TAX ID, STATUS, ADDRESS
New		Change Provider or View Favorites

REVIEW PRIORITY

Expedited Review

By checking this box and indicating that you are requesting an Expedited Review, you acknowledge that you have read and are adhering to the regulations pertaining to requesting an Expedited Review.
Medicare: 42 CFR Section 422.570
Medicaid: CFR Section 438.210
All other memberships: Health Care Reform - PPACA and DOL 29 CFR 2590.715.2710 AND 29 cfr 2560.503

NOTIFICATION/PRIOR AUTHORIZATION INPATIENT SUBMISSION

Confirm Notification/Prior Authorization

Thank you for your online Notification/Prior Authorization submission.

The notification/prior authorization case information was transmitted on 06/20/2017 at 5:10 PM CDT. The notification/prior authorization reference number is **A000333003**. Please print this page for your records.

The reference number above acknowledges receipt of your notification or prior authorization request. Please write this number down and refer to it for future inquiries. Coverage and payment for an item or service is governed by the members benefit plan document, and, if applicable, the providers participation agreement with the Health Plan.

Please note that if you wish to cancel these services at any time, or if you have any questions, please contact us by calling the number on the back of the member's ID card. Thank you.

[Expand all](#) [Collapse all](#)

ATTACH CLINICAL DOCUMENTATION

[Select files](#)

Maximum file size for upload: 25MB, per file. Acceptable file types: bmp, doc, docx, gif, jpg, jpeg, pdf, png, tiff, txt

Create Request

After searching for the patient, and selecting the appropriate **Place of Service**

- A. Choose **Select Provider** to search for the other practice or facility involved
- B. Use the pop-up to **Search** or select one from your **Favorites** tabs (not shown)

- C. Complete the **Service Details**
- D. Complete the **Dates Details**, as appropriate

- E. Complete the **Diagnosis Details** and **Procedure Details** by entering a code or keyword then selecting from the drop-down menu.

- If this is a high priority needing urgent review, check **Expedited Review** and complete the **Attestation**

- F. Complete the **Contact Details**

- G. Enter **Clinical Notes**

- H. Verify your information then **Submit**
 - For certain Diagnosis and Procedure Codes, you will be asked to complete a questionnaire when you submit the case

- I. Record the **Reference Number**

- J. **Attach Clinical Documentation**, as needed

For more **information**, please review our interactive guide at UHCprovider.com/paan.