UnitedHealthcare®

Standard Prior Authorization Request Form

Section I — Please fax your request to 866-756-9733.

Date and Time Submitted: _____ a.m. / p.m. ET/MT/CT/PT

Section II — General Information

Review Type: Routine Urgent	Clinical reason for urgency
Request Type: □Initial Request	Extension/Renewal/Amendment (Prev. Auth. #: _____)

Section III — Patient Information

Name	Patient Preferred Phone #	DOB	Sex: □ Male □ Female
Subscriber Name (if different)	Member ID #	Group #	

Section IV — Provider Information

Requesting Provider or Facility Name		***Service Provider or Facility Name***	
NPI # or Tax ID #	Specialty	NPI # or Tax ID #	Specialty
Phone	Fax	Phone	Fax
Address		Address	
Name of Primary Care Provider		Phone	Fax

Section V — Services Requested (with CPT, CDT, or HCPCS Code) and Supporting Diagnoses (with ICD-10 Code)

Planned Service or Procedure	Code(s)	Start Date	End Date	Diagnosis Description	Code(s)
□ Inpatient □ Outpatient □ Provider Office □ Observation □ Home □ Day Surgery □ Other (specify)					
□ Physical Therapy □ Occupational Therapy □ Speech Therapy □ Cardiac Rehab □ Mental Health/Substance Abuse Number of sessions Duration Frequency Other					
□ Home Health MD signed order must be attached to this request. Please also attach the nursing assessment. Number of visits requested Duration Frequency Other					
□ Durable Medical Equipment MD signed order must be attached to this request. Equipment/supplies (Include any HCPCS Codes) Duration					

Section VI — Clinical Documentation

Please provide a brief explanation of medical necessity for service(s) and attach supporting clinical documentation with this request.

Please provide contact information, in case we need more information:

Name: _____ Phone _____ (ext. _____) email _____

Preferred method of contact is: □ phone □ email

Section VII — Reason for Denial or Partial Denial
