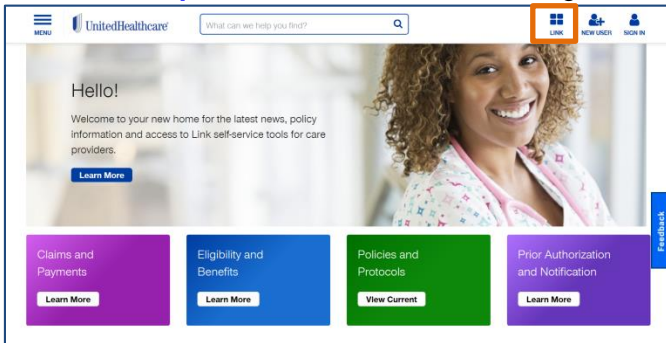


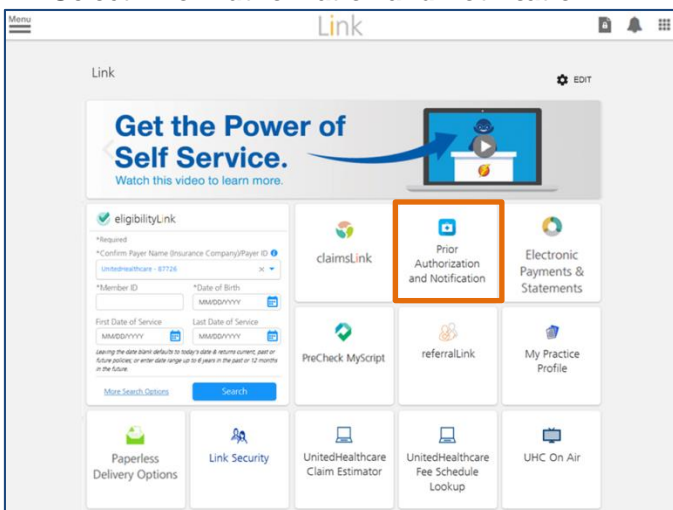
You may check to see if a Prior Authorization/Notification is required through the Prior Authorization and Notification Link application. **Note:** This app is not used for referrals. Referrals should be submitted through the eligibilityLink app.

Get Started

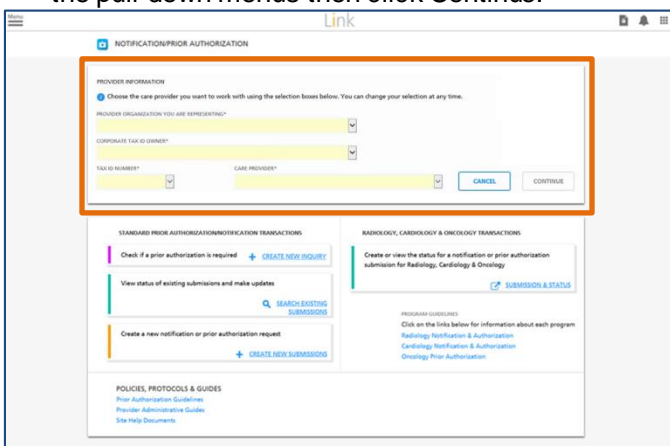
1. From UHCprovider.com, click **Link** and sign in



2. Select **Prior Authorization and Notification**

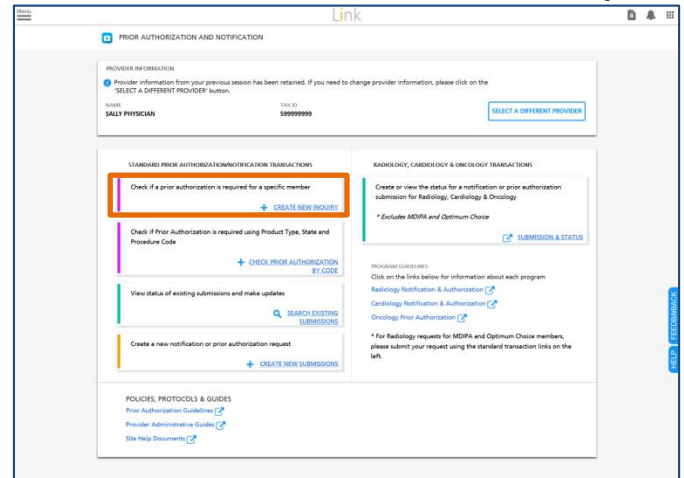


3. The first time you access this self-service tool, you must select the Care Provider you represent from the pull-down menus then click Continue.



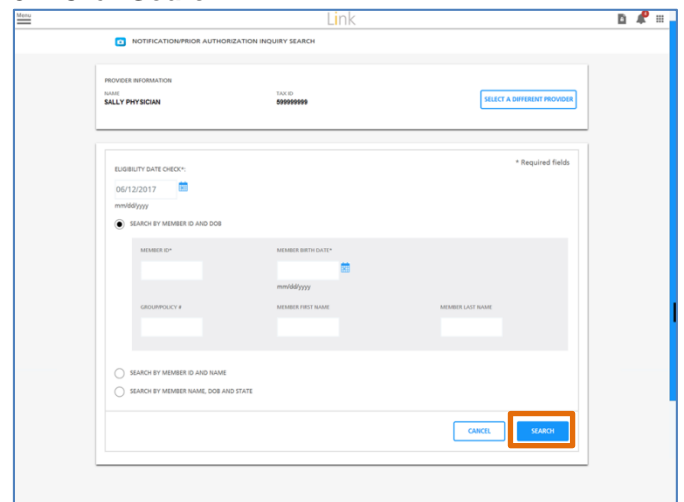
Check if a Prior Authorization is Required

1. Select **Check if a Prior Authorization is Required**



Note: The Provider Information will default to the last selected, but you may change the provider by **Selecting a Different Provider**.

2. Enter the **Date**
3. Select a **Search Method** to identify the Member (Member ID and DOB, Member ID and Name or Member Name, DOB and State)
4. Enter the required information
5. Click **Search**



Service Details

1. Choose the **Place of Service** and **Address** from the pull-down menus then click **Continue**

Link

NOTIFICATIONPRIOR AUTHORIZATION PROVIDER DETAILS

PATIENT DETAILS

PATIENT NAME	RELATIONSHIP	VERBAL LANGUAGE PREFERENCE	MESSAGE
Bob Patient	Employee	-	A future timeline may be available for this member. For future coverage please call the telephone number located on the back of the member's Medical ID card.
MEMBER NUMBER	EFFECTIVE DATE	WRITTEN LANGUAGE PREFERENCE	
0411444144	01/01/2017	-	
GROUP NUMBER	TERMINATION DATE		
092932	12/31/9999		
PRODUCT	INSURANCE TYPE		
P1 - Pos Choiceplus	Commercial		

PROVIDER INFORMATION

NAME	TAX ID
CHILDRENS HOSP	97797977

[SELECT A DIFFERENT PROVIDER](#)

Complete the selections below and select "Continue" to proceed to case details * Required fields

PLACE OF SERVICE*
Outpatient Facility

PROVIDER ADDRESS SELECTION*
40 W Blvd, Somertown, USA

[BACK](#) [CANCEL](#) [CONTINUE](#)

Inquiry Form

After completing the above steps, the **Patient Details** will appear at the top of the **Inquiry form**. Consult the following pages for detailed information.

Link

NOTIFICATIONPRIOR AUTHORIZATION INQUIRY FORM

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

PATIENT DETAILS

PATIENT NAME	RELATIONSHIP	VERBAL LANGUAGE PREFERENCE	MESSAGE
Bob Patient	Employee	-	A future timeline may be available for this member. For future coverage please call the telephone number located on the back of the member's Medical ID card.
MEMBER NUMBER	EFFECTIVE DATE	WRITTEN LANGUAGE PREFERENCE	
0411444144	01/01/2017	-	
GROUP NUMBER	TERMINATION DATE		
092932	12/31/9999		
PRODUCT	INSURANCE TYPE		
P1 - Pos Choiceplus	Commercial		

FACILITY DETAILS

NAME*	ADDRESS*
General Hospital	200 Doctors Ln, Somercty, USA
FACILITY ID NUMBER*	STATUS
97797977	In-Network

ADMITTING/ATTENDING PHYSICIAN DETAILS

NAME	ADDRESS
PATY SPECIALIST	1234 MAIN RD, ANYWHERE, US 12345
TAX ID	STATUS
511011010	In-Network

SERVICE DETAILS

PLACE OF SERVICE*	SERVICE DETAIL*
Outpatient Facility	In-Network

FACILITY SERVICE DATES DETAILS

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

ADMISSION DATE* SERVICE DISCONTINUED*

mm/dd/yyyy

DIAGNOSIS DETAILS

CODE DESCRIPTION

[Add another diagnosis code](#)

PROCEDURE DETAILS

[Add another procedure code](#)

[Back To Top](#) [CANCEL](#) [CONTINUE](#)

Diagnosis and Procedure Details

DIAGNOSIS DETAILS

CODE	DESCRIPTION	
New PNEUMO		Delete
Add another diagnosis code		

PROCEDURE DETAILS

CODE	DESCRIPTION	SERVICING PROVIDER NAME, TAX ID, STATUS, ADDRESS	
New			Change Provider or View Favorites Delete
Add another procedure code			

Type in a **Diagnosis Code/ Procedure Code** or keyword, then select from the drop-down menu

Add up to a total of **10 Diagnosis Codes** and/or **14 Procedure Codes***

DIAGNOSIS DETAILS

CODE	DESCRIPTION	
New H61.20	IMPACTED CERUMEN UNSPECIFIED EAR	Delete
Add another diagnosis code		

PROCEDURE DETAILS

CODE	DESCRIPTION	SERVICING PROVIDER NAME, TAX ID, STATUS, ADDRESS	
New 69210	Removal impacted cerumen requiring instr more		Change Provider or View Favorites Delete
SERVICE DETAILS*			
SERVICE DETAILS* Medical	EXPECTED FROM DATE* 06/22/2017	EXPECTED TO DATE* 06/30/2017	
COUNT* 1	STANDARD OF MEASURE* Days	FREQUENCY* Monthly	TOTAL* 1
Add another procedure code			

Complete additional details, if prompted

Click Continue, at the bottom of the form.

CONTINUE

Response

Menu

Link

NOTIFICATION/PRIOR AUTHORIZATION INQUIRY SEARCH RESULTS

Notification/Prior Authorization is required for the service(s) for this member. Please continue with the Notification/Prior Authorization submission process by clicking on the "Proceed with Submission" button below.

Decision ID #:D3052002

The number above acknowledges your inquiry and our response. Please write this number down and refer to it for future inquiries. Coverage and payment for an item or service is governed by the member's benefit plan document, and, if applicable, the provider's participation agreement with the Health Plan.

+ Expand all - Collapse all

PATIENT DETAILS			
PATIENT NAME	RELATIONSHIP	VERBAL LANGUAGE PREFERENCE	MESSAGE
Bob Patient	Employee	-	A future timeline may be available for this member. For future coverage please call the telephone number located on the back of the member's Medical ID card.
MEMBER NUMBER	EFFECTIVE DATE	WRITTEN LANGUAGE PREFERENCE	
04416444164	01/01/2017	-	
GROUP NUMBER	TERMINATION DATE		
0929292	12/31/9999		
PRODUCT	INSURANCE TYPE		
Pt1 - Pos Choice/plus	Commercial		

Review the response and record the **Decision ID #**

NOTE: If a Notification or Prior Authorization is not required, or your request cannot be processed, the **Decision ID #** serves as your reference number which may be needed if there are any claim issues.

Notification or Prior Authorization is not required for the requested services

Decision ID #:D3052002

The number above acknowledges your inquiry and our response. Please write this number down and refer to it for future inquiries. Coverage and payment for an item or service is governed by the member's benefit plan document, and, if applicable, the provider's participation agreement with the Health Plan.

One or more of the procedures entered should not be processed through this transaction.

Please call Behavioral Health at 800-577-7244.

Decision ID #:D3042861

The number above acknowledges your inquiry and our response. Please write this number down and refer to it for future inquiries. Coverage and payment for an item or service is governed by the member's benefit plan document, and, if applicable, the provider's participation agreement with the Health Plan.

Bottom of the response screen

STANDARD PRIOR AUTHORIZATION/NOTIFICATION TRANSACTIONS

Check if a prior authorization is required
+ CREATE NEW INQUIRY

View status of existing submissions and make updates
SEARCH EXISTING SUBMISSIONS

Create a new notification or prior authorization request
+ CREATE NEW SUBMISSIONS

RADIOLOGY, CARDIOLOGY & ONCOLOGY TRANSACTIONS

Create or view the status for a notification or prior authorization submission for Radiology, Cardiology & Oncology
SUBMISSION & STATUS

PROCEED WITH SUBMISSION

Proceed with **Submission**, if desired

Additional **Help Resources** are available at the **Link Resource Library** and **UHC on Air**