UnitedHealthcare Community Plan

Re-Review Cover Sheet
Prior Authorization Request Form

This form is a re-review cover sheet only. Please also complete and attach any drug specific forms available.
Complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
NPI #:	Phone:	Fax:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Re-Review Information (additional or missing information that may be pertinent to the decision)

- What is the original denied case number? PA-_____

- Has this request gone through the formal appeal process? □ Yes □ No
The re-review process is separate from the appeal process. Please see the original denial letter for complete information and instructions on how to file an appeal if you wish to do so.

Additional Information:
(New information that was not provided in the original case, answered questions from denial notes, labs, etc.)

_____

_____

_____

_____

Additional chart notes, labs and new information may be attached for review.

Provider Signature: _____ Date: _____