UnitedHealthcare Community Plan

# Ohio Prior Authorization Fax Request Form 1-866-839-6454

Please complete all fields on the form, and refer to the listing of services that require authorization. The list can be found at www.uhccommunityplan.com.

Date: _____ Contact Person_____
Telephone #: _____ Fax #: _____Is this a HIPAA secure fax line? Yes/No
Requesting Provider: _____ Telephone #: _____
Requesting Provider TIN/NPI: _____

## Type of Request

□ Routine □ Urgent ***Urgent is defined as "significant impact to health of the member"***
□ Expedited (**Medicare Only)** Request from physician only, *defined as "waiting for a decision under standard timeframe could place the member's life, health or ability to regain maximum functionality or would cause serious pain"*

**For Expedited or Urgent cases, the preferred method of contact is by phone. Please call request to 800.366.7304.**

## Member Information

Member Name: _____Member ID/JD#_____
Date of Birth: _____ Is member Pregnant? □ Yes □ No
Is request related to MVA or work-related injury? □ Yes □ No
Does member have other insurance? □ Yes □ No Medicare □ Part A □ Part B
Other insurance name and policy #_____

## Servicing Provider Information

Servicing Provider: _____ TIN/NPI _____

Address: _____ Fax #: _____

Date of Service:_____ PAR or Non-PAR (please circle one)
If Non-par will provider accept Medicaid/Medicare default rate - □ Yes □ No

## Type of Service

□ DME – Purchase/Rental
□ Outpatient/SDS
□ Prosthetic / Orthotics
□ Inpatient Elective Surgery
□ Transplantation Evaluation
□ Cosmetic or Reconstructive Surgery
□ PT / OT / ST
□ MRI, MRA or PET Scan
□ Gastric Bypass Eval/Surgery
□ Home Health/Hospice Services
□ Skilled Nursing Facility
□ Hysterectomy/Abortion/Sterilization
□ Out Of Network (please explain)
□ Other _____

## Clinical Information

Diagnoses:_____ICD-9 Codes: _____
CPT/HCPCS Codes: _____DME Pricing_____
Procedures: _____
Number of visits:_____ Duration:_____ Frequency: _____
Number of previous visits: _____ Service name/code for previous visits: _____

**NOTE:** In order to process your request completely and timely, submit any pertinent clinical data (i.e. progress notes, treatment rendered, tests, labs results, radiology reports) to support request for services. Any request for OON services must include documentation on the reason for the request along with the name of the OON provider. **FAILURE TO PROVIDE SUFFICIENT** INFORMATION WILL RESULT IN A DELAY IN YOUR REQUEST.