

## REQUEST FOR PRIOR APPROVAL FOR OUT-OF-NETWORK PROVIDER

Call UM at 844-854-6886 (Call Center Hours M-F 8a– 8p)

FAX Form and Clinical to 833-610-2399

**\*\*\* PLEASE DO NOT SEND REQUESTS FOR MULTIPLE MEMBERS TOGETHER IN ONE FAX – MUST SEND SEPARATELY\*\*\***

**\*PRIOR AUTHORIZATION IS REQUIRED FOR SERVICES BY ANY NON-PARTICIPATING PROVIDER.** Payment is authorized only for the medical services noted below, and is subject to the limitations and exclusions as outlined in the Member Handbook/Certificate of Coverage.

<b>Member Data</b>	<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border-bottom: 1px solid black;">Member Name</td> <td style="width: 33%; border-bottom: 1px solid black;">Date of Birth</td> <td style="width: 33%; border-bottom: 1px solid black;">Member's Plan ID</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Name of Nursing Facility</td> <td style="border-bottom: 1px solid black;">Referring Provider</td> <td style="border-bottom: 1px solid black;">Is Referring Provider: <input type="checkbox"/> Plan NP <input type="checkbox"/> PCP <input type="checkbox"/> Plan PA <input type="checkbox"/> Other</td> </tr> <tr> <td colspan="3" style="border-bottom: 1px solid black;">Diagnoses (ICD-10 Codes) Related to Auth Request</td> </tr> </table>	Member Name	Date of Birth	Member's Plan ID	Name of Nursing Facility	Referring Provider	Is Referring Provider: <input type="checkbox"/> Plan NP <input type="checkbox"/> PCP <input type="checkbox"/> Plan PA <input type="checkbox"/> Other	Diagnoses (ICD-10 Codes) Related to Auth Request		
Member Name	Date of Birth	Member's Plan ID								
Name of Nursing Facility	Referring Provider	Is Referring Provider: <input type="checkbox"/> Plan NP <input type="checkbox"/> PCP <input type="checkbox"/> Plan PA <input type="checkbox"/> Other								
Diagnoses (ICD-10 Codes) Related to Auth Request										
<b>Service</b>	Date of Procedure/Service: _____ CPT Code or Name of Procedure/Service: _____									

**SERVICES REQUESTED (include copy of order and the clinical notes)**

<b>Specialist/Ancillary Provider/Facility</b>	Provider Name (REQUIRED): _____ Provider Contact Number (REQUIRED): _____ Provider Specialty (REQUIRED): _____ In Network (REQUIRED): <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Requesting Provider</b>	1. Is this member new enrollee with the Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Has this provider seen this member in the last 30 days: <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Has the service been scheduled already: <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Is this a specialized service that no other provider can render: <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Does the member have an established relationship with the provider that should not be interrupted? <input type="checkbox"/> Yes <input type="checkbox"/> No  If Yes, Explain: _____

**TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION**

Name of Person Completing this Form: _____	Date Completed: _____
(Please Print Name)	
Contact #: _____	Contact FAX: _____