LONGEVITY HEALTH PLAN

REQUEST FOR PRIOR AUTHORIZATION to OTHER HEALTHCARE PROFESSIONAL

***Call** UM at 888-886-9770 opt 3 (Call Center Hours M-F 8a– 5p)* ***FAX** Form and Clinical to 1-833-610-2399*

**** 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. (ATTACH OON FORM)** 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.

Member Data

Member Name _____ **Date of Birth** _____ **Member's Plan ID** _____

Is Referring Provider: ☐ Plan NP

Name of Nursing Facility _____ **Referring Provider** _____ ☐ PCP ☐ Plan PA ☐ Other

Service

Diagnoses (ICD-10 Codes) Related to Auth Request _____

Date of Procedure/Service: _____ **CPT Code or Name of Procedure/Service**: _____

SERVICES REQUESTED

(include copy of order or clinical note for out-of-network requests) (ATTACH OON FORM)

Other HealthCare Professional

Provider Name (REQUIRED): _____

Provider Contact Number (REQUIRED): _____

Provider Specialty (REQUIRED): _____

In Network (REQUIRED): Circle Correct Answer: **YES** ☐ **NO** ☐

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

Name of Person Completing this Form: _____ **Date Completed:** _____

(Please Print Name)

Contact #: _____ **Contact FAX:** _____