

REQUEST FOR PRIOR APPROVAL FOR OUT-OF-NETWORK PROVIDER

Call UM at 888-585-1611 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.** 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.

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| Member Data | <p>Member Name _____ Date of Birth _____ Member's Plan ID _____</p> <p>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</p> <p>Diagnoses (ICD-10 Codes) Related to Auth Request _____</p> |
| Service | <p>Date of Procedure/Service: _____ CPT Code or Name of Procedure/Service: _____</p> |
| SERVICES REQUESTED (include copy of order and the clinical notes) | |
| Specialist/Ancillary Provider/Facility | <p>Provider Name (REQUIRED): _____</p> <p>Provider Contact Number (REQUIRED): _____</p> <p>Provider Specialty (REQUIRED): _____</p> <p>In Network (REQUIRED): <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| Requesting Provider | <p>1. Is this member new enrollee with the Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Has this provider seen this member in the last 30 days: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Has the service been scheduled already: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Is this a specialized service that no other provider can render: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Does the member have an established relationship with the provider that should not be interrupted? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="text-align: center;">If Yes, Explain: _____</p> |

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

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

Contact #: _____ Contact FAX: _____