

## REQUEST FOR PRIOR AUTHORIZATION to OTHER HEALTHCARE PROFESSIONAL

Call UM at 888-585-1611 opt 3 (Call Center Hours M-F 8a- 5p)

FAX Form and Clinical to 888-585-1631

**\*\*\* 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.

<b>Member Data</b>	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 or clinical note for out-of-network requests) **(ATTACH OON FORM)**

<b>Other HealthCare Professional</b>	Provider Name (REQUIRED): _____ Provider Contact Number (REQUIRED): _____ Provider Specialty (REQUIRED): _____ In Network (REQUIRED): Circle Correct Answer:      YES                  NO
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**TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION**

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

Contact #: \_\_\_\_\_ Contact FAX: \_\_\_\_\_