UM Department Phone #: 844-824-8653
UM Department Fax #: 888-522-6740

(For Claim Denial or Prior Authorization Denial, please submit an Appeal through Customer Service at 1-844-243-5175)

PLEASE COMPETE ALL SECTIONS WITH AN ASTERISK AND ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NECESSITY.

Requestor's Contact Name:	Requestor's Contact #:
Patient Information:	
*Name:	*DOB:
*Medicaid ID	*Patient Phone #:
*Service Is: ☐ Standard ☐ Expedited	Reason for Expedited:
Note: Documentation from a physician needs to be attached for expedited requests detailing the issue(s) that document could seriously jeopardize the enrollee's life, health or ability to obtain, maintain or regain maximum function	
Service Type Requested: Please review plans benefit prior to request	***Place of Service:**

Inpatient	Outpatient	Other
☐ Emergent Inpatient	☐ Surgical Procedure	☐ Home Health /Skilled Services
☐ Concurrent Review	☐ Physical Therapy	☐ (SN/PT/OT/SP)
☐ Observation Stay >48 hrs	☐ Occupational Therapy	☐ Private Duty Nursing
☐ Surgical Procedures	☐ Speech Therapy	☐ (see PDN specific form)
☐ Elective Admission	☐ Chiropractic Services	☐ DME
☐ Skilled Nursing Facility	☐ Chemotherapy	☐ Hearing Aids
☐ Long-Term Acute Care	☐ Imaging	☐ Prosthetics/Orthotics
☐ Acute Rehab	☐ Sleep Study	☐ Transportation / Transfers
☐ Maternity	☐ Pain Management	☐ Genetic Testing
☐ NICU Stay	☐ Colonoscopy / EGD	☐ Other:
☐ Hospice	☐ Intensive Cardiac & Pulmonary Rehab	
☐ Transplant	☐ Pre/Post Transplant Services	

Procedure Information:	
***ICD 10** Diagnosis:	Diagnosis Description:
***CPT/HCPC** Code & Description *(Include Unit of Measure / Frequency for supplies):*	
*Date(s) of Service:	# of Units or Visits:
Provider Information:	
Requesting Provider	Is this the patient's Primary Care Physician? ☐ Yes. ☐ No
*Name:	*NPI TIN:
*Phone:	*Fax
*Address:	
Rendering Provider (If Requesting and Rendering providers differ, complete section below)	☐ Same as the Requesting Provider
*Name:	*NPI TIN:
*Phone:	*Fax
*Address:	
Facility	☐ N/A
*Name:	*NPI TIN:
*Phone:	*Fax
*Address:	
Request for extension to existing authorization number:	

PLEASE COMPETE ALL SECTIONS WITH AN ASTRICK AND ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NECESSITY.
INCOMPLETE INFORMATION MAY DELAY THE PROCESS.

Always verify eligibility, benefits and prior authorization requirements