



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

Requestor's Contact Name: _____ Requestor's Contact #: _____

Patient Information:

*Name: _____ *DOB: _____
 *Patient ID #: _____ *Patient Phone #: _____
 *Service Is: Elective / Routine Expedited / Urgent

Note: Selected Expedited/ Urgent to prevent serious deterioration in health or jeopardize ability to regain maximum function.

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

***Service Type Requested:** Please review plans benefit prior to request

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

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

Same as the Requesting Provider

If Requesting and Rendering providers differ, complete section below

*Name: _____ *NPI _____ *TIN: _____

*Phone: _____ *Fax _____

*Address: _____

Facility

N/A

*Name: _____ *NPI _____ *TIN: _____

*Phone _____ *Fax _____

*Address _____

Request for extension to existing authorization number:

PLEASE COMPLETE 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

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time of services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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