REQUEST FOR REFERRAL FOR TELEHEALTH or SPECIALIST PRIOR AUTH

***Call** UM at 844-206-1205 (Call Center Hours M-F 8a– 8p)* ***FAX** Form and Clinical to 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** _____

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

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

Service

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

SERVICES REQUESTED

Specialist – PA **Telehealth Referral-include copy of order** **Out of Network- (ATTACH OON FORM)**

Specialist

Provider Name (REQUIRED): _____

Provider Contact Number (REQUIRED): _____

Provider Specialty (REQUIRED): _____

In Network (REQUIRED): Circle Correct Answer: YES ☐ NO ☐ Number of Visits Requested: _____

Telehealth

Vendor Name (REQUIRED): _____

Vendor Contact Number (REQUIRED): _____

Specialty (REQUIRED): _____

In Network (REQUIRED): Circle Correct Answer: YES ☐ NO ☐ Number of Visits Requested: _____

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

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

(Please Print Name)

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