



REQUEST FOR PRIOR APPROVAL FOR OUT-OF-NETWORK PROVIDER

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

SERVICES REQUESTED (include copy of order and the clinical notes)

Specialist/Ancillary Provider/Facility	Provider Name (REQUIRED): _____ Provider Contact Number (REQUIRED): _____ Provider Specialty (REQUIRED): _____ In Network (REQUIRED): <input type="checkbox"/> Yes <input type="checkbox"/> No
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Requesting Provider	1. Is this member new enrollee with the Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Has this provider seen this member in the last 30 days: <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Has the service been scheduled already: <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Is this a specialized service that no other provider can render: <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Does the member have an established relationship with the provider that should not be interrupted? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Explain: _____
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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: _____