REQUEST FOR REFERRAL TO SPECIALIST, PSYCHIATRY, TELEHEALTH AND OTHER HEALTHCARE PROFESSIONAL

Call UM at: 844-305-3879 (CA), 844-788-8935 (FL), 855-855-0336 (MI), 844-854-6885 (OR) or 855-855-0489 (VA)
(Call Center Hours: 8am – 8pm LOCAL TIME)

FAX Form and Clinical to 833-610-2399

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. *** PLEASE INCLUDE ONLY ONE MEMBER PER SUBMISSION.***

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

Referral-include copy of order **PA-include clinical** **Out of Network- (ATTACH OON FORM)**

Specialist/HealthCare Professional

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:** ____________________