



## REQUEST FOR PRIOR APPROVAL FOR OUT-OF-NETWORK PROVIDER

Call UM at 844-205-7244 opt 3 (Call Center Hours M-F 8a- 5p)

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.

<b>Member Data</b>	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 _____
<b>Service</b>	Date of Procedure/Service: _____ CPT Code or Name of Procedure/Service: _____

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

<b>Specialist/Ancillary Provider/Facility</b>	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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<b>Requesting Provider</b>	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: \_\_\_\_\_