United Healthcare Community Plan

Prior authorization request for air transportation, lodging and meals

Urgent: ☐ Yes Today's date _____ Fax to 800-267-8328

Member information

Name (Last, First, Middle):		Member Plan ID#	Gender ☐M ☐F
Home street address (Do not enter P.O. Box):			
ZIP:	Phone:	Alternate phone:	DOB
Contact person (Relationship):		Phone	

PCP information

PCP name:	Contact name:
Phone:	Fax:

Referring medical provider information

Name (Last, First, Middle)			Specialty:
Contact name:		Phone:	Fax:

Appointment information

Treatment/description of medical service: ☐ Consult ☐ Follow-up ☐ Other:			
Medical reason for treatment (including diagnosis)			
Reason for request (i.e., no specialist on island of residence, procedure cannot be done on island or residence, etc.)			
Rendering physician:		Phone:	Specialty:
Start date mm/dd/yy:	Check-in time:	End date mm/dd/yy:	End time:
Physical street address:			Island or state:
Facility:		City:	ZIP:
Additional appointment:	Rendering physician:	Phone:	Specialty:
Start date dd/mm/yy	Check-in time	End date dd/mm/yy	End time:
Physical street address:			Island or state:
Facility:		City:	ZIP:

Travel request information: Please attach clinical information to support any request to travel out of state.

Departure city/airport:		Arrival city/airport	
Departure date dd/mm/yy Return date dd/mm/yy	Medical reason for stay longer than 1 day:		
Type of ticket: ☐ One-way ☐ Round-trip	Attendant required: ☐ Yes ☐ No	Medical reason for attendant:	
Name of adult attendant (as listed on valid photo ID):		Gender: ☐M ☐F	DOB:
Ground transportation required: ☐ Home island ☐ Neighbor island ☐ Mainland ☐ Not required			
Do not use this field to indicate a need for airport W/C assistance Member provides W/C? ☐ Yes ☐ No What type?_____ Able to transfer in/out of W/C? ☐ Yes ☐ No			
Meals Required: ☐ Yes ☐ No	Lodging Required: ☐ Yes ☐ No	Oxygen Required: ☐ Yes ☐ No If Yes: ☐ Nasal ☐ Mask O2 Flow Rate:	

Comments

Other special travel needs/comments: