UnitedHealthcare®

Michigan Prior Authorization Fax Request Form

Please complete all fields on the form. Submit all relevant clinical data such as progress notes, treatment rendered, tests, lab results, and radiology reports to support the request for services. This will help us process your request without delay. Failure to provide sufficient information will delay your request. Refer to the list of services that require authorization at UHCprovider.com. Please fax the completed form to us at **855-225-9847**. If you have questions, please call us at **800-903-5253.**

Date: _____ Contact person: _____ Phone: _____

Fax: _____ HIPAA secure fax line? ☐ Yes ☐ No

Requesting Provider: _____ TIN/NPI: _____

Member Information

Member name: _____ Member ID/JD#:_____

Member date of birth: _____ Member pregnant? ☐ Yes ☐ No

Related to a motor vehicle accident or work-related injury? ☐ Yes ☐ No

Member have other insurance? ☐ Yes ☐ No If yes, Medicare ☐ Part A ☐ Part B

Other insurance name and policy #_____

Type of Request

Request must include a physician's order stating that waiting for a decision under a standard timeframe could endanger the member's life, health, or ability to regain maximum functionality or would cause serious pain.

☐ Routine ☐ Expedited/Urgent

☐ Inpatient ☐ Outpatient ☐ Home

Servicing Provider and Facility Information

Servicing provider: _____ TIN/NPI: _____

Address: _____ Fax: _____

Date of service: _____ In network ☐ Out of network ☐

Servicing facility: _____ TIN/NPI:_____

Address:_____ In network ☐ Out of network ☐

Will out of network provider accept Medicaid/Medicare default rate? ☐ Yes ☐ No

Clinical Information

Diagnoses: _____ ICD-9 codes: _____

Required CPT/HCPCS Code(s): _____

Miscellaneous and/or unlisted codes description required: _____

Number of visits: _____ Start date:_____ End date: _____

Frequency: _____DME Cost: $_____

Number of previous visits/service description/CPT/HCPCS codes?: _____