UnitedHealthcare Community Plan

Mississippi Prior Authorization Fax Request Form 888-310-6858

Please complete all fields on the form and refer to the listing of services that require authorization. The list can be found at uhccommunityplan.com.

Date:_____ Contact Person_____

Telephone#:_____Fax#:_____Is this a HIPAA secure fax line? ☐ Yes ☐ No

Requesting Provider:_____Telephone#:_____

Requesting Provider TIN/NP!: _____

Type of Request:

☐ Routine ☐ Urgent ***Urgent is defined as "significant impact to health of the member"***

☐ Expedited **(Medicare Only)** Request from physician only, *defined as "waiting for a decision under standard timeframe could place the member's life, health or ability to regain maximum functionality or would cause serious pain"*

For Expedited or Urgent cases, the preferred method of contact is by phone. Please call request to 866.604.3267.

Member Information:

Member Name:_____Member ID/JD#_____Date of Birth:_____

I member Pregnant? ☐ Yes ☐ No

Is request related to MVA or work-related injury? ☐ Yes ☐ No

Does member have other insurance? ☐ Yes ☐ No Medicare ☐ Part A ☐ Part B

Other insurance name and policy#_____

Servicing Provider Information:

Servicing Provider:_____TIN/NP! _____

Address:_____ Fax#: _____

Date of Service:_____PAR or Non-PAR (please circle one) If

Non-par will provider accept Medicaid/Medicare default rate - ☐ Yes ☐ No

Type of Service:

☐ DME - Purchase/Rental
☐ OutpatienUSDS
☐ Prosthetic / Orthotics
☐ Inpatient Elective Surgery
☐ Transplantation Evaluation
☐ Cosmetic or Reconstructive Surgery
☐ PT/ OT/ ST
☐ MRI, MRA or PET Scan
☐ Gastric Bypass Eval/Surgery
☐ Home Health/Hospice Services
☐ Skilled Nursing Facility
☐ Hysterectomy/Abortion/Sterilization
☐ Out Of Network (please explain)
☐ Other _____

Clinical Information:

Diagnoses:_____ICD-10 Codes: _____

CPT/HCPCS Codes:_____DME Pricing_____

Procedures:_____

Number of visits:_____Duration:_____Frequency: _____

Number of previous visits:_____Service name/code for previous visits: _____

NOTE: In order to process your request completely and timely, submit any pertinent clinical data (i.e. progress notes, treatment rendered, tests, labs results, radiology reports) to support request for services. Any request for OON services must include documentation on the reason for the request along with the name of the OON provider. **FAILURE TO PROVIDE SUFFICIENT INFORMATION WILL RESULT IN A DELAY IN YOUR REQUEST.**