UnitedHealthcare Community Plan

# Ohio Medicaid Medical Prior Authorization Supplemental Information Sheet

Please complete all fields on the form for any service requiring authorization. Submitting all relevant clinical data such as progress notes, treatment rendered, tests, lab results, and radiology reports will help us process your request without delay. Failure to provide sufficient information may delay your request.

A complete list of services requiring prior authorization can be found at **https://www.uhcprovider.com/en/health-plans-by-state/ohio-health-plans/oh-comm-plan-home/oh-cp-prior-auth.html**

Date:_____Contact person:_____

Phone:_____ Fax:_____HIPAA secure fax line? ☐ Yes ☐ No

Requesting Provider:_____TIN/NPI: _____

## Member Information

Member name:_____Member ID#:_____Date of birth: _____

## Type of Request

☐ Inpatient ☐ Outpatient ☐ Home Care ☐ Private Duty Nursing ☐ DME ☐ Therapy ☐ Medications

## Servicing Care Provider and Facility Information

Servicing care provider: _____ TIN/NPI: _____

Address:_____ OH Medicaid ID:_____

Date of service: _____ Fax: _____

Servicing facility: _____ In network ☐Out of network ☐

Address: _____ TIN/NPI: _____

Facility OH Medicaid ID: _____ In network ☐Out of network ☐

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

## Clinical Information

Diagnoses:_____ICD-10 codes: _____

Required: CPT/HCPCS Code(s): _____

Description required: _____

Miscellaneous and/or unlisted codes: _____

Please provide the requested number of units/mg/mcg_____

Number of visits:_____Start date:_____End date: _____

Frequency:_____Durable medical equipment cost: $_____

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

Clinical information:_____

_____

_____

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***Please attach relevant clinical data such as progress notes, evaluations, treatment rendered, tests, lab results, md order/prescriptions, and/or radiology reports when you submit your request.**