REQUEST FOR REFERRAL & PRIOR AUTH FOR SPECIALIST, TELEHEALTH AND OTHER HEALTHCARE PROFESSIONAL

See Authorization/Referral Chart

Call UM at 844-896-0628 opt 3 (Call Center Hours M-F 8a– 5p) ***FAX Form and Clinical to 800-504-4752***

****** 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. (ATTACH OON FORM)** 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.

Member Data

______________________ ______________ ____________________

Member Name **Date of Birth** **Member's Plan ID**

______________________ ____________________ Is Referring Provider: ☐ Plan NP

Name of Nursing Facility **Referring Provider** ☐ PCP ☐ Plan PA ☐ Other

Diagnoses (ICD-10 Codes) Related to Auth Request ____________________________________

Service

Date of Procedure/Service: ______________________**CPT Code or Name of Procedure/Service**: ______________________

SERVICES REQUESTED

Referral-include copy of order **PA-include clinical** **Out of Network- (ATTACH OON FORM)**

Specialist/HealthCare Professional

Provider Name (REQUIRED): ____

Provider Contact Number (REQUIRED): ____

Provider Specialty (REQUIRED): ____

In Network (REQUIRED): Circle Correct Answer: YES NO Number of Visits Requested: ______

Telehealth

Vendor Name (REQUIRED): ____

Vendor Contact Number (REQUIRED): ____

Specialty (REQUIRED): ____

In Network (REQUIRED): Circle Correct Answer: YES NO Number of Visits Requested: _________

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

Name of Person Completing this Form: ______________________ **Date Completed:** ____________________

(Please Print Name)

Contact #: ______________________________ **Contact FAX:** ______________________