UnitedHealthcare Community Plan of Mississippi prior authorization fax request form

Please complete this form and fax it to 888-310-6858. For more information regarding prior authorization requests, visit **uhcprovider.com/priorauth.**

Date:	Contact person:
Telephone number:	Fax number:
Is this a HIPAA® secure fax line? Yes No	
Requesting care provider:	Telephone number:
Requesting care provider tax ID number (TIN)/National Provider Identifier (NPI) number:	

Type of request

Routine   Urgent   (Urgent is defined as significant impact to the health of the member)

Expedited **(Medicare only)** request from physician only, is 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 prior authorization requests, please call 877-842-3210.

Member information

Member name:	Member ID number:
Date of birth:	Is member pregnant? Yes No
Is request related to a motor vehicle accident or work-related injury? Yes No	
Does member have other insurance? Yes No Medicare Part A Part B	
Other insurance name and policy number:	

Servicing provider information

Servicing provider:		TIN/NPI:
Address:		
City:	State:	ZIP code:
Fax number:		Date of service:
Network or Out-of-nework (please check one)		
If out-of-network, will care provider accept Medicaid/Medicare default rate? Yes No		

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Type of service

☐ DME – Purchase/rental	☐ Cosmetic or reconstructive surgery	☐ Skilled nursing facility
☐ Outpatient USDS	☐ PT/OT/ST	☐ Hysterectomy/abortion/ sterilization
☐ Prosthetic/orthotics	☐ MRI, MRA or PET scan	☐ Out-of-network (please explain)
☐ Inpatient elective surgery	☐ Gastric bypass evaluation/surgery	☐ Other:
☐ Transplantation evaluation	☐ Home health/hospice services	

Clinical information

Diagnosis:	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 (progress notes, treatment rendered, tests, labs results, radiology reports) to support request for services. Any request for out-of-network services must include documentation regarding the reason for the request, along with the name of the out-of-network care provider. **If you don't provide sufficient information, your prior authorization request will be delayed.**

CPT® is a registered trademark of the American Medical Association.

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