UM Department Phone #: 844-824-8846
UM Fax #: 888-522-6490

Requestor's Contact Name:	Requestor's Contact #:
Patient Information:	
*Name:	*DOB:
*Patient ID #:	*Patient Phone #:
*Service Is: ☐ Elective / Routine	☐ Expedited / Urgent

Note: Selected Expedited/ Urgent to prevent serious deterioration in health or jeopardize ability to regain maximum function.

(For Claim Denial or Prior Authorization Denial, please submit an Appeal through Customer Service at 1-844-243-5181)

***Service Type Requested:** Please review plans benefit prior to request

Inpatient	Outpatient	Other
☐ Emergent Inpatient	☐ Surgical Procedure	**Home Health /Skilled Services** (SN/PT/OT/SP)
☐ Concurrent Review	☐ Physical Therapy	☐ Private Duty Nursing
☐ Observation Stay >24 hrs	☐ Occupational Therapy	☐ DME
☐ Surgical Procedures	☐ Speech Therapy	☐ Hearing Aids
☐ Elective Admission	☐ Chemotherapy	☐ Prosthetics/Orthotics
☐ Skilled Nursing Facility	☐ Dialysis	☐ Transportation / Transfers
☐ Long-Term Acute Care	☐ Imaging	☐ Air Ambulance
☐ Acute Rehab	☐ Sleep Study (facility based)	☐ DNA/Genetic Testing
☐ Maternity	☐ Pain Management	☐ Sleep Study (facility based)
☐ NICU Stay	☐ Pre/Post Transplant Service	☐ Other:
☐ Hospice	☐ High Cost Medication >$1000 (administered in office)	________________
☐ Transplant		

Procedure Information:

*ICD 10 Diagnosis:	Diagnosis Description:
*CPT/HCPC Code & Description *(Include Unit of Measure / Frequency for supplies):*	
*Date(s) of Service:	# of Units or Visits:

Provider Information:

Requesting Provider	Is this the patient's Primary Care Physician? ☐ Yes ☐ No	
*Name:	*NPI	TIN:
*Phone:	*Fax	
*Address:		
Rendering Provider If Requesting and Rendering providers differ, complete section below	☐ Same as the Requesting Provider	
*Name:	*NPI	*TIN:
*Phone:	*Fax	
*Address:		
Facility	☐ N/A	
*Name:	*NPI	*TIN:
*Phone	*Fax	
*Address		

Request for extension to existing authorization number:

PLEASE COMPETE ALL SECTIONS WITH AN ASTRICK AND ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NECESSITY.
INCOMPLETE INFORMAITON MAY DELAY THE PROCESS.

Always verify eligibility, benefits and prior authorization requirements

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time of services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in the transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient and use, distribute, or coping is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.