



**REQUEST FOR REFERRAL & PRIOR AUTHORIZATION FOR TELEHEALTH
REQUEST FOR PRIOR AUTH TO OTHER HEALTHCARE PROFESSIONAL**

Call UM at 844-224-3659 opt 3 (Call Center Hours M-F 8a- 5p)

FAX Form and Clinical to 800-489-9518

***** 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 _____
	Name of Nursing Facility _____ Referring Provider _____ Is Referring Provider: <input type="checkbox"/> Plan NP <input type="checkbox"/> PCP <input type="checkbox"/> Plan PA <input type="checkbox"/> 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)

HealthCare Professional	Provider Name (REQUIRED): _____ Provider Contact Number (REQUIRED): _____ Provider Specialty (REQUIRED): _____ In Network (REQUIRED): Circle Correct Answer: YES NO Number of Visits Requested: _____
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Telehealth	Vendor Name (REQUIRED): _____ Vendor Contact Number (REQUIRED): _____ Specialty (REQUIRED): _____ In Network (REQUIRED): Circle Correct Answer: YES NO Number of Visits Requested: _____
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TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION	
Name of Person Completing this Form: _____ (Please Print Name)	Date Completed: _____
Contact #: _____	Contact FAX: _____