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

Call UM at: 1-855-855-0668 (GA) or 1-855-855-0759 (NC/SC)
(Call Center Hours: 8am – 8pm LOCAL TIME)

FAX Form and Clinical to 833-610-2399

****** 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)**

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:** _____