

REQUEST FOR PRIOR AUTHORIZATION FOR OUT OF NETWORK

See Authorization/Referral requirements on the Authorization/Referral Chart

Call UM at 844-637-4760 opt 3 (Call Center Hours M-F 8a- 5p)

FAX Form and Clinical to 800-541-9048

***** 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)**

Specialist/HealthCare Professional/Psychiatry	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: _____