UnitedHealthcare Community Plan

Louisiana Prior Authorization Fax Request Form 877-271-6290

Please complete all fields on the form, and refer to the listing of services that require authorization. The list can be found at UHCCommunityPlan.com

Date: _____ Contact Person_____

Telephone #: _____ Fax #: _____Is this a HIPAA secure fax line? □ Yes □ No

Requesting Provider: _____ Telephone #: _____

Requesting Provider TIN/NPI: _____

Type of Request:

□ Routine □ Urgent *Urgent is defined as* **"Medical care provided for a condition that without timely treatment, could be expected to deteriorate into an emergency, or cause prolonged, temporary impairment in one or more bodily function, or cause the development of a chronic illness or need for a more complex treatment"**

For Expedited or Urgent cases, the preferred method of contact is by phone. Please call request to 866-604-3267.

Member Information:

Member Name: _____Member ID/JD#_____ Date of Birth: _____
Is member Pregnant? □ Yes □ No
Is request related to MVA or work-related injury? □ Yes □ No
Does member have other insurance? □ Yes □ No Medicare □ Part A □ Part B
Other insurance name and policy #_____

Servicing Provider Information:

Servicing Provider: _____ TIN/NPI _____

Address: _____ Fax #: _____

Date of Service:_____ PAR or Non-PAR (please circle one)
If Non-par will provider accept Medicaid/Medicare default rate - □ Yes □ No

Type of Service:

□ Outpatient/SDS
□ Inpatient Elective Surgery
□ Transplantation Evaluation
□ MRI, MRA or PET Scan
□ Transplantation Evaluation
□ Cosmetic or Reconstructive Surgery
□ PT / OT / ST
□ Out Of Network (please explain)
□ Gastric Bypass Eval/Surgery
□ Home Health/Hospice Services
□ Hysterectomy/Abortion/Sterilization
□ Other _____

Clinical Information:

Diagnoses:_____ICD-9 Codes: _____

CPT/HCPCS Codes: _____

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 (i.e. progress notes, treatment rendered, tests, labs results, radiology reports) to support request for services. Any request for OON services must include documentation on the reason for the request along with the name of the OON provider. **FAILURE TO PROVIDE SUFFICIENT INFORMATION WILL RESULT IN A DELAY IN YOUR REQUEST.**