

Prior authorization request form

Overview

Please complete this form to request prior authorization. For a list of services that require authorization, visit UHCprovider.com/MOcommunityplan > [Prior Authorization and Notification](#). If you have questions, please call us at **800-366-7304**.

Date:

Contact person:

Phone:

Requesting health care professional name:

Tax ID number (TIN) / National Provider Identifier (NPI) number:

Member information

Member name:

Member ID/JD #:

Date of birth:

Is the member pregnant? Yes No

Is the request related to a motor vehicle accident or work-related injury? Yes No

Does the member have other insurance? Yes No If yes, Medicare Part A Part B

If member has other insurance, list the name and policy #:

Type of request

Inpatient Outpatient Home Routine Expedited/Urgent

For urgent requests, please include a physician's order stating that waiting for a decision under a standard time frame could endanger the member's life, health or ability to regain maximum functionality or would cause serious pain.

Servicing health care professional and facility information

Servicing health care professional name:	TIN/NPI number:
Address:	Fax:
Date of service:	Network Out-of-network
Service facility:	TIN/NPI:
Address:	Network Out-of-network
Will out-of-network health care professional accept Medicaid/Medicare default rate? Yes No	

Clinical information

Diagnosis:	ICD-10 codes:	
Required CPT®/HCPCS code(s):		
Miscellaneous and/or unlisted codes description required:		
Number of visits:	Start date:	End date:
Frequency of durable medical equipment (DME) use:	DME cost: \$	
Please list the number of previous visits/service description/CPT/HCPCS codes:		

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