Prior Authorization Request Form
UM Department Fax: 909-494-3229

MEMBER INFORMATION*Ask Member if they have a new Phone Number/Address							
Plan Info:	Plan Name:	Line of Business:	REQUEST DATE:	☐Other:			
				MRN#:			
Member Name:		DOB:		☐MEMBER REQUEST ONLY			
Member Address:		Phone:*	( ) -	Member ID#:			

Service Type: NOTE:		
*URGENT - *Seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function.* **Must have direct communication with Medical Director or designee.*	☐ Elective/Routine	
	☐ Expedited/Urgent*	
	☐ Emergent**	

REQUESTING PROVIDER INFORMATION	
Requesting Provider Name:	Provider Phone #: ( ) - ext.:
Contact at Requesting Provider's office:	Fax Number #: ( ) -

Referral/Service Type Requested (Check off as appropriate for request):

Inpatient:	Outpatient				
☐Surgical procedures	☐Surgical Procedure	☐Rehab (PT, OT, & ST)	☐Home Health (POS 11)	☐ CONSULT (99204)	☐ INPATIENT (POS 21)
☐ER Admits	☐Diagnostic Procedure	☐Chiropractic	☐DME/Item	☐ FOLLOW UP (99214)	☐ Outpatient Hospital (POS 22)
☐SNF	☐Wound Care	☐Infusion Therapy	☐In Office (POS 11)	CPT Code & Description:	☐ Ambulatory Surgery Center (POS 24)
☐Rehab	☐Other:	☐Radiology			
☐LTAC					

Diagnosis Code (ICD10) & Description:			
Name/Address of ***REQUESTED*** Provider:		Provider Phone #: ( ) -	
		Fax Number #: ( ) -	
Name of ***REQUESTED*** Facility for Surgery:		Number of visits/days requested:	Date(s) of Service: If surgery, what date scheduled?

Supporting Documentation Requirements:

CARDIOLOGY	NEPHROLOGY	NEUROSURGERY	ONCOLOGY	ORTHOPEDICS	PULMONARY	UROLOGY	
☐ Clinical Notes	☐ Clinical Notes	☐ Clinical Notes	☐ Clinical Notes (H&P)	☐ Clinical Notes	☐ Spirometry	☐ Clinical notes	☐ PT Notes
☐ EKG	☐ Bun/ Creatine	☐ MRI, CT	☐ Operative report	☐ X-ray report	☐ O2 sat	☐ Urine culture	☐ OT Notes
☐ PTCA, CABG	☐ Kidney ultrasound	☐ Neurology Records	☐ Pathology report	☐ MRI report	☐ Chest x-rays	☐ Urine cytology	☐ ST Notes
☐ STRESS ECHO		☐ Pain Management Records	☐ Previous radiology reports		☐ CT report	☐ PSA blood test	☐ Physician Orders & Notes
☐ CHEST X-RAY						☐ CT Abd/pelvis	

Clinical Signs & Symptoms (Reason for consult?)

*** In addition to this form, submit 1) a complete history and physical, 2) an applicable current/complete note that is legible, and 3) all pertinent test results. (i.e. Clinical notes, medication list, Labs, X-rays, and pertinent outside clinical records). Please fax completed form and supporting documents to the UM Referral Department to fax number: ( ) -

Provider Signature (Electronic Signature is Permissible):

*Requesting Provider Signature:	Date Signed:
Signature above denotes agreement for UM Dept. updating Requested Provider if new Consult or Out of Area/Network Provider requested.	**SPECIFY Total Number of Pages Faxed:**