



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:* () -							
Service Type: <u>NOTE:</u> <u>*URGENT - Seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function.</u> **Must have direct communication with Medical Director or designee.			☐ Elective/Routine						
			☐ <u>Expedited/Urgent*</u>						
			☐ <u>Emergent**</u>						
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: ☐ Surgical procedures ☐ ER Admits ☐ SNF ☐ Rehab ☐ LTAC		Outpatient ☐ Surgical Procedure ☐ Diagnostic Procedure ☐ Wound Care ☐ Other: ☐ Rehab (PT, OT, & ST) ☐ Chiropractic ☐ Infusion Therapy ☐ Radiology		☐ Home Health (POS 11)		☐ CONSULT (99204)		☐ INPATIENT (POS 21)	
				☐ DME/Item		☐ FOLLOW UP (99214)		☐ Outpatient Hospital (POS 22)	
				☐ In Office (POS 11)		CPT Code & Description:		☐ Ambulatory Surgery Center (POS 24)	
Diagnosis Code (ICD10) & Description:									
Name/Address of <u>REQUESTED</u> Provider:				Provider Phone #: () -					
				Fax Number #: () -					
Name of <u>REQUESTED</u> Facility for Surgery:				Number of visits/days requested:		Date(s) of Service: If surgery, what date scheduled?			
Supporting Documentation Requirements:									
CARDIOLOGY ☐ Clinical Notes ☐ EKG ☐ PTCA, CABG ☐ STRESS ECHO ☐ CHEST X-RAY	NEPHROLOGY ☐ Clinical Notes ☐ Bun/ Creatine ☐ Kidney ultrasound	NEUROSURGERY ☐ Clinical Notes ☐ MRI, CT ☐ Neurology Records ☐ Pain Management Records	ONCOLOGY ☐ Clinical Notes (H&P) ☐ Operative report ☐ Pathology report ☐ Previous radiology reports	ORTHOPEDICS ☐ Clinical Notes ☐ X-ray report ☐ MRI report	PULMONARY ☐ Spirometry ☐ O2 sat ☐ Chest x-rays ☐ CT report	UROLOGY ☐ Clinical notes ☐ Urine culture ☐ Urine cytology ☐ PSA blood test ☐ CT Abd/pelvis	☐ PT Notes ☐ OT Notes ☐ ST Notes ☐ Physician Orders & Notes		
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:				