Universal Healthcare

Provider Reminders — Referrals, Documentation & Prior Authorization

Check Prior Authorization Requirements Before Submitting

We have noticed a significant increase in authorization submissions for services that do not require prior authorization. This creates unnecessary administrative burden and delays processing for all providers and members. Before submitting any auth request, please consult the General Authorization Information guide located on our website under "For Providers > Reference Material" to confirm whether the service requires prior authorization.

⚠️ **Submitting auths for non-required services causes processing delays. Always verify requirements before submitting.**

Use the Provider Reference Portal for In-Network Referrals

When referring members for care, please visit our Universal Healthcare website under "For Providers > Reference Material" to locate contracted, in-network providers before making a referral. In-network options are available for: Urgent Care, Laboratory Services, Radiology, and Physical Therapy. Using contracted providers helps avoid unexpected out-of-pocket costs for your patients and prevents potential claim delays or denials.

Out-of-Network Referrals — Required Information

When an out-of-network (OON) provider is clinically necessary, all of the following must be included on the referral submission. Incomplete referrals will be returned, which can significantly delay care for your patient:

- Clinical reason / justification for use of an out-of-network provider
- Out-of-network provider contact information
- Provider NPI (National Provider Identifier) and TIN (Tax Identification Number)

⚠️ **Missing information will result in delay or cancellation. Please review all fields before submitting.**

Universal Healthcare

Provider Reminders — Referrals, Documentation & Prior Authorization

Include Supporting Clinical Documentation with All Requests

To facilitate a prompt review and approval process, kindly ensure that all relevant supporting documentation is attached to every submission. Requests lacking sufficient clinical support may necessitate additional follow-up, which can prolong the review process and, in turn, delay care for your patient. When applicable, please include the following:

- Recent clinical or progress notes
- Lab results and diagnostic findings
- Imaging reports or pertinent test results

Understanding Request Types: Expedited vs. Standard

When submitting prior authorization requests, please ensure you are selecting the correct request type. Using the appropriate designation helps us prioritize and process requests accurately and on time.

Expedited Request

Required when a delay in care could seriously jeopardize the member's life, health, or ability to regain maximum function.

Turnaround: 72 hours

Standard Request

Used for non-urgent, routine requests where a delay in care would not seriously jeopardize the member's health or safety.

Turnaround: 7 calendar days

Last Updated: 6/04/2026