



General Prior Authorization Request Form

FYI Review our provider manual criteria references. Submit documentation to support medical necessity along with this request. Failure to provide required documentation may result in denial of request.



Fax form and any relevant clinical documentation to:
612-884-2499 or **1-866-610-7215**.



For questions, call: **612-676-3300**
or **1-888-531-1493**

PATIENT INFORMATION	Member Name _____	Member ID _____
	Member Address _____	PMI _____
	Member City, State, Zip _____	Date of Birth _____
	Member Phone _____	
ORDERING PROVIDER INFORMATION	Ordering Provider Name _____	ID/NPI Number _____
	Ordering Provider Address _____	
	Ordering Provider City, State, Zip _____	
	Ordering Provider Phone _____	Fax _____
SERVICE PROVIDER INFORMATION	Service Provider Contact Person _____	
	Service Provider Name _____	ID/NPI Number _____
	Service Provider Address _____	
	Service Provider City, State, Zip _____	
	Service Provider Phone _____	Fax _____
	Service Provider Email _____	
ADMINISTRATIVE INFORMATION	<input type="checkbox"/> Standard Request	<input type="checkbox"/> Expedited Request
	Standard review timeframe for an authorization decision is within 14 calendar days or 10 business days from the date the request was received, as expeditiously as the member's health condition requires.	Expedited review timeframe for urgent/emergent requests within 72 hours , as expeditiously as the member's health condition requires. Only request an expedited review if waiting the standard review timeframe would potentially jeopardize the member's health, life or ability to regain function.
	Physician/Staff Name _____	Date _____
	Physician/Staff Signature _____	Phone _____
	Request sent by _____	
	Total Pages Faxed _____	

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SERVICE PROCEDURE/ ITEMS REQUESTED	<p>Reason for prior authorization request (select one):</p> <p><input type="checkbox"/> UCare prior authorization requirement</p> <p><input type="checkbox"/> Out of network provider request (include referring provider information)</p> <p style="margin-left: 40px;">Physician Name _____</p> <p style="margin-left: 40px;">Clinic/Facility _____</p> <p style="margin-left: 40px;">Contact phone number _____</p> <p><input type="checkbox"/> Experimental/Investigational</p> <p>Procedure code(s) HCPCS or CPT _____</p> <p>Description of request</p> <p>_____</p> <p>_____</p> <p>Relevant ICD10 code(s) _____</p> <p>Diagnosis description (include all) relevant to this request</p> <p>_____</p> <p>_____</p> <p>Number of Units/Visits Requested _____ Frequency (if applicable) _____</p> <p>Start Date Requested _____ (mm/dd/yy) (required)</p> <p>End Date Requested _____ (mm/dd/yy)</p>
CRITERIA	<p>Confirm and complete the required steps to proceed:</p> <p><input type="checkbox"/> Clinical notes supporting any of the above have been included in the submitted information.</p>

Notes: Do not use this form for Injectable Drug Authorization Request, DME Authorization, Home Care Services, or Medicare Pre-Determination.

Please allow 14 calendar days for decision. **Submission of all relevant clinical information with the request will reduce the number of days for the decision.**