

### Mississippi Prior Authorization Fax Request Form 888-310-6858

Please complete all fields on the form, and refer to the listing of services that require authorization. The list can be found at [uhccommunityplan.com](http://uhccommunityplan.com).

Date: \_\_\_\_\_ Contact Person \_\_\_\_\_

Telephone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ Is this a HIPAA secure fax line?  Yes  No

Requesting Provider: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Requesting Provider TIN/NPI: \_\_\_\_\_

**Type of Request:**

- Routine  Urgent *Urgent is defined as "significant impact to health of the member"*
- Expedited (**Medicare Only**) Request from physician only, defined as "waiting for a decision under standard timeframe could place the member's life, health or ability to regain maximum functionality or would cause serious pain"

**For Expedited or Urgent cases, the preferred method of contact is by phone. Please call request to 866.604.3267.**

**Member Information:**

Member Name: \_\_\_\_\_ Member ID/JD# \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Is member Pregnant?  Yes  No

Is request related to MVA or work-related injury?  Yes  No

Does member have other insurance?  Yes  No Medicare  Part A  Part B

Other insurance name and policy # \_\_\_\_\_

**Servicing Provider Information:**

Servicing Provider: \_\_\_\_\_ TIN/NPI \_\_\_\_\_

Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

Date of Service: \_\_\_\_\_ PAR or Non-PAR (please circle one)

If Non-par will provider accept Medicaid/Medicare default rate -  Yes  No

**Type of Service:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> DME – Purchase/Rental      | <input type="checkbox"/> Cosmetic or Reconstructive  | <input type="checkbox"/> Home Health/Hospice Services        |
| <input type="checkbox"/> Outpatient/SDS             | <input type="checkbox"/> Surgery                     | <input type="checkbox"/> Skilled Nursing Facility            |
| <input type="checkbox"/> Prosthetic / Orthotics     | <input type="checkbox"/> PT / OT / ST                | <input type="checkbox"/> Hysterectomy/Abortion/Sterilization |
| <input type="checkbox"/> Inpatient Elective Surgery | <input type="checkbox"/> MRI, MRA or PET Scan        | <input type="checkbox"/> Out Of Network (please explain)     |
| <input type="checkbox"/> Transplantation Evaluation | <input type="checkbox"/> Gastric Bypass Eval/Surgery | <input type="checkbox"/> Other _____                         |

**Clinical Information:**

Diagnoses: \_\_\_\_\_ ICD-9 Codes: \_\_\_\_\_

CPT/HCPCS Codes: \_\_\_\_\_ DME Pricing \_\_\_\_\_

Procedures: \_\_\_\_\_

Number of visits: \_\_\_\_\_ Duration: \_\_\_\_\_ Frequency: \_\_\_\_\_

Number of previous visits: \_\_\_\_\_ Service name/code for previous visits: \_\_\_\_\_

**NOTE:** In order to process your request completely and timely, submit any pertinent clinical data (i.e. progress notes, treatment rendered, tests, labs results, radiology reports) to support request for services. Any request for OON services must include documentation on the reason for the request along with the name of the OON provider. **FAILURE TO PROVIDE SUFFICIENT INFORMATION WILL RESULT IN A DELAY IN YOUR REQUEST.**