



Delaware Prior Authorization Fax Request Form 1-877-877-8230

Please complete all fields on the form, and refer to the listing of services that require authorization. The list can be found at www.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 800.366.7304.

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:

- DME – Purchase/Rental Cosmetic or Reconstructive Home Health/Hospice Services
 Outpatient/SDS Surgery Skilled Nursing Facility
 Prosthetic / Orthotics PT / OT / ST Hysterectomy/Abortion/Sterilization
 Inpatient Elective Surgery MRI, MRA or PET Scan Out Of Network (please explain)
 Transplantation Evaluation Gastric Bypass Eval/Surgery 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.**