

PREAUTHORIZATION REQUEST FORM

FAX COMPLETED FORM WITH SUPPORTING MEDICAL DOCUMENTATION TO:

SECTION 1 - MEMBER INFORMATION					
First Name:	Last Name:			Date of Birth:	Medicaid#
SECTION 2 – HEALTHCARE PROVIDER INFORMATION					
Referring Provider Name: Provider's Specialty:					
Office Phone #:			Referring Provider Fax #:		
Servicing Provider Name:			Servicing Provider NPI #:		
Office Phone #:			Servicing Provider Fax #:		
Vendor/Facility Name & Address:			Vendor/Facility NPI:		
DME Request Services under \$500 on the Medicaid Fee Schedule do not require authorization.					
SECTION 3 – SERVICE INFORMATION					
*CPT codes are used to determine the type of services requested. Authorization of these services assumes that you will bill with codes billable under the current Medicaid Fee Schedule. Please contact your Provider Relations representative if you have any questions.					
Diagnosis Code(s)			Diagnosis Code Description(s)		
CPT/HCPCS Code(s)			CPT/HCPCS Code Description(s)		
Admit Date/Scheduled Date of Service:					
SECTION 4 – ADDITIONAL INFORMATION					
NOTE: This request must be accompanied by a physician's order and/or all other pertinent clinical					
documentation for appropriate evaluation. Additional documentation may include, but is not limited to:					
- Physicians' Orders - Progress Notes - Clinical Summary Diagnostic Test Results - Prior Treatments - Discharge Information					
For DME: Depresentation Physician's Order Attached Depresentation of Medical Necessity (CMN) Attached					
SECTION 5 – APPROVAL INFORMATION (For UM Health Partners Use Only)					
Authorization #:			Approval Date Range: —		
Approval Date:		Revi	Reviewer/Approver:		
SECTION 6 – REQUESTOR INFORMATION					
Contact Name:					
Callback Phone #:		Callb	allback Fax #:		
Date of Request: (All routine requests will be responded to within 48 hours of request receipt by Health Services Dept.)					
SECTION 7 – URGENT REQUEST					
Could the member's health be harmed by waiting 48 hours for a decision on this request? Yes, then please call 1-800-730-8543 for expedited review. 					
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If you need to speak to a Utilization Management Representative, call 1-800-730-8543 Option "1". SERVICES ARE NOT CONSIDERED AUTHORIZED UNTIL UNIVERSITY OF MARYLAND HEALTH PARTNERS ISSUES AN APPROVAL. This authorization does not guarantee payment of claim.					

All authorizations are subject to eligibility requirements and benefit plan limitations.