

Medical Access Program
Clinical Services Prior-Authorization Request Form

Complete **all** information and **send supporting medical documentation with** request.

Retrospective requests are not accepted.

- New request Extension of an existing authorization Request due to ER Referral
 Out-of-network In-network not available within 30 days Continuity of care, last appt. date: ___/___/___
 Urgent (A request is considered urgent if service is needed within 24 hours or less based on member's medical condition.)

Member: _____ **ID#** _____ **DOB:** ___/___/___

Referring To:

Physician: _____ <small>(Print first and last name.)</small> _____ <small>(Address/City/State/Zip)</small>	Specialty: _____ _____ <small>Phone number / extension Fax number</small>
Facility: _____ <small>(Print entire facility name.)</small> _____ <small>(Address/City/State/Zip)</small>	Department: _____ _____ <small>Phone number / extension Fax number</small>
ICD-9 Code(s): _____ Diagnoses: _____	

Type of Service Requested: (check all that apply)**

Physician office: <input type="checkbox"/> Physician office visit / Consult Date of appointment: ___/___/___	Facility: <input type="checkbox"/> Outpatient Surgery <input type="checkbox"/> Outpatient test(s) Date of appt./surgery: ___/___/___
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Please note: Allow a maximum of 14 calendar days and a minimum of 2 business days for processing of request
Do not resend request. Phone calls regarding status will be accepted.

Requesting Physician:

Physician: _____	Contact name: _____
Request date: ___/___/___	_____ <small>Phone number / extension Fax number</small>

Fax to (906) 225-7720.

www.uphp.com (Medical Access Program)

All referrals are subject to medical review. Authorization does not guarantee payment. Benefit determinations are subject to diagnosis eligibility, member eligibility, and plan benefits at the time services are provided.

Determination: (To be completed by M.A.P. staff) M.A.P. Staff: _____ Decision Date: ___/___/___

_____ No. of Visits ___ Begin ___/___/___ End ___/___/___
Authorization Number

Comments: _____

Redirect to in-plan provider; services are available in-plan.

Requesting Provider: Please send a copy of this authorization request to the referred provider.