Clinical Services Prior Authorization Request Form

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

Retrospective requests are not accepted.

☐ New referral ☐ Extension of an existing referral

☐ Out-of-plan ☐ In-plan 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: _____ **Medicaid ID#** _____ **DOB:**____/____/____

Referring To:

Physician: _____ **Specialty:** _____
(Print first and last name)

_____ (____) _____ (____) _____
(Address/City/State/Zip) *Phone number / extension* *Fax number*

Facility: _____ **Department:** _____
(Print entire facility name)

_____ (____) _____ (____) _____
(Address/City/State/Zip) *Phone number / extension* *Fax number*

ICD-9 Code(s): _____ **Diagnoses:** _____

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

Physician office:	**Facility:**
☐ Physician office visit / Consult	☐ Surgery ☐ Outpatient ☐ Inpatient ☐ Outpatient test(s)
Date of appointment: ____/____/____	Date of appt/surgery: ____/____/____

Please note: Allow a maximum of 14 business days and a minimum of 2 business days for UPHP processing of request.

Do not resend request. *Phone calls regarding status will be accepted.*

Referring Physician:

Physician: _____ Contact name: _____

Request date: ____/____/____ (____) _____ (____) _____
Phone number / extension *Fax number*

Fax to (906) 225-7720
or send to UPHP, 228 W. Washington Street, Marquette, MI 49855
www.uphp.com

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 UPHP Staff)* *UPHP Staff:* _____

Authorization #_____ # of Visits ____ Begin____/____/____ End____/____/____

Decision Date: ____/____/____ Comments: _____

_____

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

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