UPHP
UPPER PENINSULA HEALTH PLAN

UPHP PRIOR AUTHORIZATION (PA) REQUEST FORM
FAX TO 906-225-9269

Date of Request

Complete Sections A - E – Send supporting notes / documentation – No retrospective requests

A. Please check Member's Plan	☐ UPHP Medicaid	☐ UPHP CSHCS	☐ UPHP Healthy Michigan Plan	☐ UPHP BMP	☐ UPHP Medicare	☐ UPHP MI Health Link

B. Member:

Name:_____ *Last, First, Middle Initial*	UPHP ID #:_____	DOB: _____
PCP:	Diagnosis:	ICD 10:

REQUESTOR:	☐ PCP	☐ Specialist (notify PCP of referral)
Office contact:	Phone:	Fax:
Requestor enrolled in CHAMPS* ☐ Yes ☐ No	NPI Number:	

*In order to receive payment the referring provider must be enrolled in the Community Health Automated Medicaid Processing System (CHAMPS) for all Medicaid programs. All Hospital facilities and attending providers must be registered in CHAMPS to receive payment for all Medicaid programs.

C. REFERRED TO:

Physician/Practitioner*:	Phone:	Fax:
Specialty:		
Address:		
Facility:	Phone:	Fax:
Address:		
*If unknown, please notify UPHP when scheduled	**Date of Admission/appointment if known**:	

D. REASON FOR AUTHORIZATION REQUEST:

Out-of-plan:
- ☐ No in-plan provider available
- ☐ Higher level of care
- ☐ Extension of existing Prior Authorization
- ☐ Emergency Department/Hospitalization Follow-up
- ☐ Other

In-Plan:
- ☐ Surgery (PA Required: Bariatric, reconstructive, dental)
- ☐ UPHP Medicare/MI Health Link Inpatient / Observation
- ☐ Long Term Care Admission (MI Health Link)
- ☐ Other_____

E. TYPE OF SERVICE REQUESTED:

Out-of-plan:
- ☐ Office Visit
- ☐ Outpatient (includes any plan benefit testing / procedures)
- ☐ Inpatient/observation admission
- ☐ Long Term Care Admission (MI Health Link)
- ☐ Other

Urgency of Request:
- ☐ Standard/Routine
- ☐ Expedited/urgent- request that if waiting for a decision under standard timeframes would place the member's life, health or ability to regain maximum function in serious jeopardy. If request is outside of this definition it should be submitted as Standard/Routine.

UPHP STAFF ONLY

DETERMINATION: **UPHP STAFF**_____ **DECISION DATE:** _____

☐ Approved ☐ Denied (Letter sent to member and requesting provider)

Out-of-plan**:** #_____Office visits #_____Outpatient visits
Inpatient/Observation Admission _____(UPHP requires initial clinical notes, weekly updates and notice of discharge)

☐ GLOBAL AUTHORIZATION**:** (# of visits as needed - Office and Outpatient services – does NOT include Inpatient)

In-plan: _____ Admission Date
- ☐ UPHP Medicare/MI Health Link Inpatient / Observation
- ☐ Long Term Care Admission (MI Health Link)
- ☐ Surgery_____

AUTHORIZATION #:_____
COMMENTS: _____
START DATE: _____ **END DATE:** _____

Authorization does not guarantee payment.
All authorized items and services are subject to review for medical necessity, member eligibility, member plan benefits, and provider eligibility for payment at the time of service.