



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:
UPHP ID #:
DOB:
PCP:
Diagnosis:
ICD 10:
REQUESTOR:
Office contact:
Requestor enrolled in CHAMPS*
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.

C. REFERRED TO:
Physician/Practitioner*:
Specialty:
Address:
Facility:
Address:
Date of Admission/appointment if known:

D. REASON FOR AUTHORIZATION REQUEST:
E. TYPE OF SERVICE REQUESTED:
Out-of-network:
Other Services:
Office Visit
Outpatient
Urgency of Request:

UPHP STAFF ONLY
DETERMINATION:
UPHP STAFF:
DECISION DATE:
Out-of-network:
GLOBAL AUTHORIZATION:
In-network:
AUTHORIZATION #:
COMMENTS:
START DATE:
END DATE: