



# Upper Peninsula Health Plan (UPHP) Online Clinical Submission Form User Guide

[www.uphp.com/clinicalsubmissionform/](http://www.uphp.com/clinicalsubmissionform/)

[www.uphp.com/contactus/](http://www.uphp.com/contactus/)

As of December 17, 2025, UPHP members, their authorized representatives, or providers can use the UPHP Online Clinical Submission Form to submit the following to UPHP:

- Clinical Services – Appeals:
  - Member appeal requests.
  - Provider claim appeal requests.
  - Medical records to support a clinical appeal or quality of care grievance.
- Clinical Services – Utilization Management:
  - Out-of-Network Provider prior authorization requests.
    - In-Network Providers must use the UPHP Assist Portal to request prior authorization.
  - Upper Peninsula Health Plan (UPHP) MI Health Link (Medicare-Medicaid Plan) Member prior authorization requests.
    - Medicaid, Healthy Michigan Plan (HMP), and Children’s Special Healthcare Services (CSHCS) members must have a provider request prior authorization for them.
  - Provider skilled care notifications and updates.
  - Provider hospital inpatient and observation admission notifications and updates.
  - Medical records to support a prior authorization request or admission notification.

This form only accepts the items listed above. If you need to send something else to a different UPHP team, please go to the UPHP Contact Us webpage. If you have questions about the online form, please go to the UPHP Contact Us webpage and contact the UPHP Help Desk.

## Table of Contents

|  |    |
|--|----|
| Step 1: Select The UPHP Team .....   | 2  |
| Step 2: Pick a Form Type.....  | 2  |
| Appeals: Submit Medical Records .....  | 3  |
| Appeals: Submit an Appeal Request .....  | 6  |
| Utilization Management (UM): Submit Medical Records.....                         | 9  |
| Utilization Management (UM): Submit a Prior Authorization Request.....           | 12 |
| Utilization Management (UM): Submit a Hospital or Skilled Care Notification..... | 16 |

## Step 1: Select The UPHP Team

### Which UPHP team should get this form?

- Clinical Services - Appeals
- Clinical Services - Utilization Management

Providers, members or their authorized representatives may use the online form to submit information to the following UPHP Clinical teams:

- Clinical Services – Appeals:
  - Pre-service and post-service appeal requests.
  - Medical records to support an appeal or quality of care grievance.
- Clinical Services – Utilization Management:
  - Prior authorization requests.
  - Notifications and updates for skilled nursing, long term care and hospital inpatient/observation admissions.
  - Medical records to support a prior authorization request or notification.

## Step 2: Pick a Form Type

The image shows two side-by-side screenshots of a web form. Both screenshots have the heading "Which UPHP team should get this form?".  
The left screenshot shows the "Clinical Services - Appeals" radio button selected. Below it is a "Form Type:" label and a dropdown menu. The dropdown menu is open, showing three options: "Select Form Type" (with a downward arrow), "Submit Medical Records", and "Submit an Appeal Request".  
The right screenshot shows the "Clinical Services - Utilization Management" radio button selected. Below it is a "Form Type:" label and a dropdown menu. The dropdown menu is open, showing three options: "Select Form Type" (with a downward arrow), "Submit Medical Records", "Submit a Hospital or Skilled Care Notification", and "Submit a Prior Authorization (PA) Request".

Use the Table of Contents on Page 1 to skip to instructions for each Form Type.

- Clinical Services – Appeals:
  - Submit Medical Records: Submit medical records to support an appeal or quality of care grievance.
  - Submit an Appeal Request: Submit a request for a pre-service or post-service appeal.
- Clinical Services – Utilization Management:
  - Submit Medical Records: Submit medical records to support a prior authorization request or notification.
  - **Providers Only:** Submit a Hospital or Skilled Care Notification: Submit notifications and updates for skilled care, long term care, and hospital inpatient and observation admissions.
  - Submit a Prior Authorization (PA) Request: Submit a request for a prior authorization.


## Appeals: Submit Medical Records

Use this form to submit medical records to the UPHP Clinical Services – Appeals team.

1. Enter the UPHP member's information.

**Member Information**

**Member First Name:**  **Member Last Name:**

**Member Date of Birth:**   **Member ID:**

2. Select the UPHP member's current health plan – Medicaid or Medicare.

**Member's Health Plan:**

The member is enrolled in UPHP Medicaid, Healthy Michigan Plan (HMP) or Children's Special Health Care Services (CSHCS)

The member is enrolled in UPHP MI Health Link (MHL)

3. Select who is submitting the form.

**Submitter Information**

**Who is submitting this form?**

I am a UPHP Member

I am a UPHP Member's Authorized Representative or Legal Guardian

I am a Provider

If you are an authorized representative or guardian, please note that UPHP must have valid representative documents on file before we can start working on the appeal. A link to an appointment of representative PDF form will become available if you pick this option.

**Who is submitting this form?**

I am a UPHP Member

I am a UPHP Member's Authorized Representative or Legal Guardian

I am a Provider

UPHP members can have a relative, friend, attorney (lawyer), doctor or someone else act as their representative. The member (or their legal guardian) and the person they want to act for them must sign and date a form saying this is what they want. If we do not get the information we need, such as a signed request or proof of guardianship, the appeal may be dismissed. [Appointment of Representative Form](#)

4. Enter your contact information in the Submitter Information fields.
  - a. Call Back Extension is optional.
  - b. A Fax Number OR Email Address must be entered.

|                                     |                                 |   |  |
|-------------------------------------|---------------------------------|---|--|
| <b>Submitter First Name:</b>        |                                 | <b>Submitter Last Name:</b>             |  |
| <input type="text"/>                |                                 | <input type="text"/>                    |  |
| <b>Call Back Number:</b>            | <b>Call Back Extension:</b>     |   |  |
| <input type="text"/>                | <input type="text"/>            |   |  |
| <b>Submitter Mailing Address 1:</b> |                                 | <b>Submitter Mailing Address 2:</b>     |  |
| <input type="text"/>                |                                 | <input type="text"/>                    |  |
| <b>Submitter Mailing City:</b>      | <b>Submitter Mailing State:</b> | <b>Submitter Mailing Zip Code:</b>      |  |
| <input type="text"/>                | <input type="text"/>            | <input type="text" value="XXXXX-XXXX"/> |  |
| <b>Fax Number:</b>                  | <b>Email Address:</b>           |   |  |
| <input type="text"/>                | <input type="text"/>            |   |  |

5. If someone at UPHP asked you to submit this form, pick yes for the question below and enter their first name and last name or initial.

|  |                                   |                                  |
|--|-----------------------------------|----------------------------------|
| Did someone from UPHP ask you to submit this request? <input type="button" value="YES"/> |                                   |                                  |
| <b>First Name</b>  | <b>Last Name/Initial</b>          |                                  |
| Please enter their name:   | <input type="text" value="JANE"/> | <input type="text" value="DOE"/> |

6. Enter the reason for submitting the records to UPHP in the Reason for Submission text box.

|  |
|--|
| Reason for Submission:   |
| <input style="width: 100%; height: 40px;" type="text" value="Example: Submitting medical records to support Sally's appeal of a denied prior authorization to see an out-of-network doctor."/> |

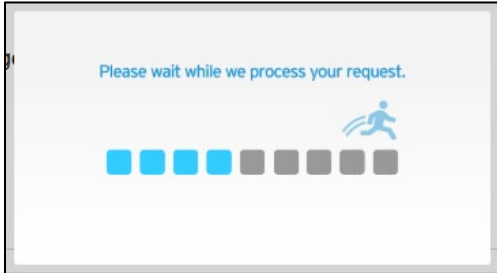
7. Use the Choose File button to attach documents such as medical records, prescriptions, orders, test results, receipts, or letters. The form will accept PDF's, images, Word documents, and text files. More than one document can be attached.

|   |
|---|
| <p><b>Attach Documents</b></p> <p>Please attach documents you have to support the request. Some examples are medical records, prescriptions, orders, test results, receipts, or letters.</p> <p style="text-align: center;"> <input type="button" value="Choose File"/> No file chosen         </p> |
|---|

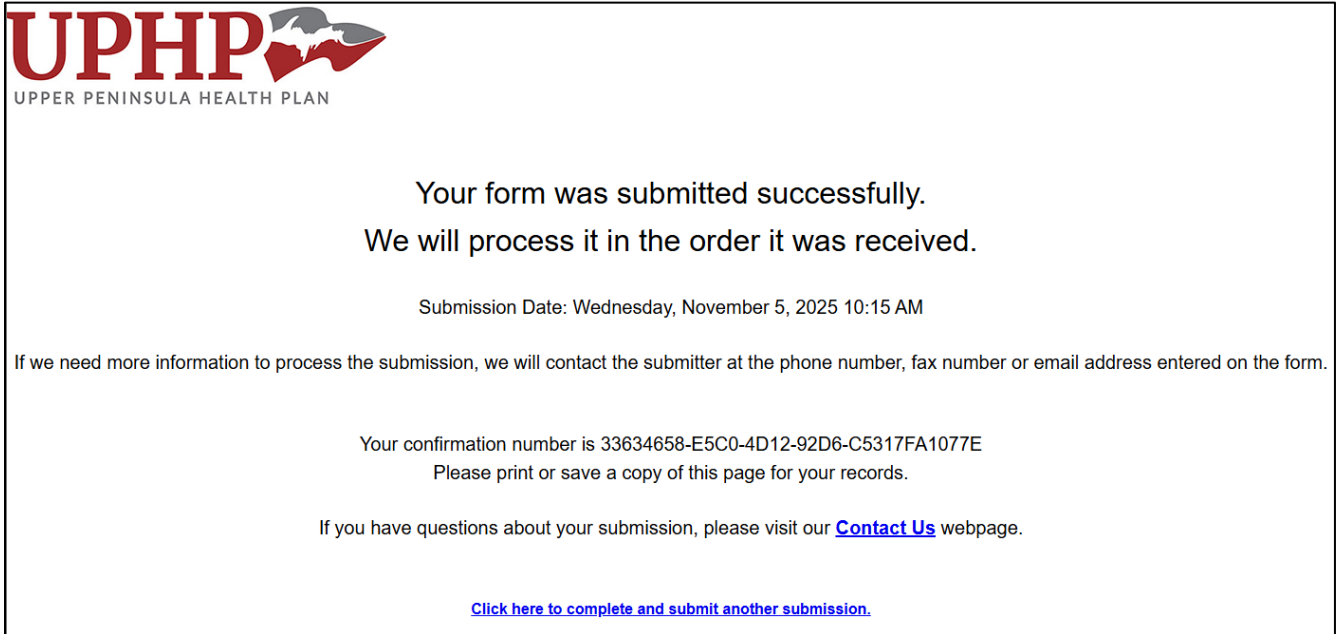
8. Submit the form after filling in all fields and attaching documents.



While the form is submitting a loading image may appear:



9. Once the form is submitted, you will see a success page as shown below.




## Appeals: Submit an Appeal Request

Use this form to submit medical records to the UPHP Clinical Services – Appeals team.

1. Enter the UPHP member's information.

**Member Information**

**Member First Name:**  **Member Last Name:**

**Member Date of Birth:**   **Member ID:**

2. Select the UPHP member's current health plan – Medicaid or Medicare.

**Member's Health Plan:**

The member is enrolled in UPHP Medicaid, Healthy Michigan Plan (HMP) or Children's Special Health Care Services (CSHCS)

The member is enrolled in UPHP MI Health Link (MHL)

3. Select who is submitting the form.

**Submitter Information**

**Who is submitting this form?**

I am a UPHP Member

I am a UPHP Member's Authorized Representative or Legal Guardian

I am a Provider

If you are an authorized representative or guardian, please note that UPHP must have valid representative documents on file before we can start processing the appeal. A link to an appointment of representative form will be available if this option is picked.

**Who is submitting this form?**

I am a UPHP Member

I am a UPHP Member's Authorized Representative or Legal Guardian

I am a Provider

UPHP members can have a relative, friend, attorney (lawyer), doctor or someone else act as their representative. The member (or their legal guardian) and the person they want to act for them must sign and date a form saying this is what they want. If we do not get the information we need, such as a signed request or proof of guardianship, the appeal may be dismissed. [Appointment of Representative Form](#)

4. Enter your contact information in the Submitter Information fields.
  - a. Call Back Extension is optional.
  - b. A Fax Number OR Email Address must be entered.

|                                     |                                 |   |  |
|-------------------------------------|---------------------------------|---|--|
| <b>Submitter First Name:</b>        |                                 | <b>Submitter Last Name:</b>             |  |
| <input type="text"/>                |                                 | <input type="text"/>                    |  |
| <b>Call Back Number:</b>            | <b>Call Back Extension:</b>     |   |  |
| <input type="text"/>                | <input type="text"/>            |   |  |
| <b>Submitter Mailing Address 1:</b> |                                 | <b>Submitter Mailing Address 2:</b>     |  |
| <input type="text"/>                |                                 | <input type="text"/>                    |  |
| <b>Submitter Mailing City:</b>      | <b>Submitter Mailing State:</b> | <b>Submitter Mailing Zip Code:</b>      |  |
| <input type="text"/>                | <input type="text"/>            | <input type="text" value="XXXXX-XXXX"/> |  |
| <b>Fax Number:</b>                  | <b>Email Address:</b>           |   |  |
| <input type="text"/>                | <input type="text"/>            |   |  |

5. If someone at UPHP asked you to submit this form, pick yes for the question below and enter their first name and last name or initial.

|  |                                   |                                  |
|--|-----------------------------------|----------------------------------|
| Did someone from UPHP ask you to submit this request? <input type="button" value="YES"/> |                                   |                                  |
| <b>First Name</b>  | <b>Last Name/Initial</b>          |                                  |
| Please enter their name:   | <input type="text" value="JANE"/> | <input type="text" value="DOE"/> |

6. Enter the reason for submitting the appeal to UPHP in the Reason for Submission text box.

|  |
|--|
| Reason for Submission:   |
| <input style="width: 100%; height: 40px;" type="text" value="Example: Submitting medical records to support Sally's appeal of a denied prior authorization to see an out-of-network doctor."/> |

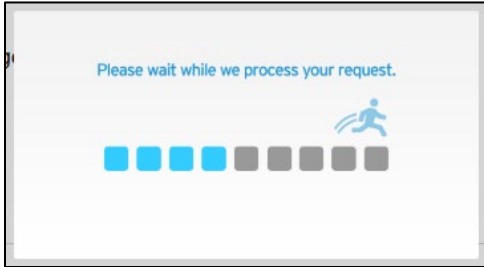
7. Use the Choose File button to attach documents. Some examples are medical records, prescriptions, orders, test results, receipts, or letters. The form will accept PDF's, images, Word documents, and text files. More than one document can be attached.

|   |
|---|
| <p><b>Attach Documents</b></p> <p>Please attach documents you have to support the request. Some examples are medical records, prescriptions, orders, test results, receipts, or letters.</p> <p style="text-align: center;"> <input type="button" value="Choose File"/> No file chosen         </p> |
|---|

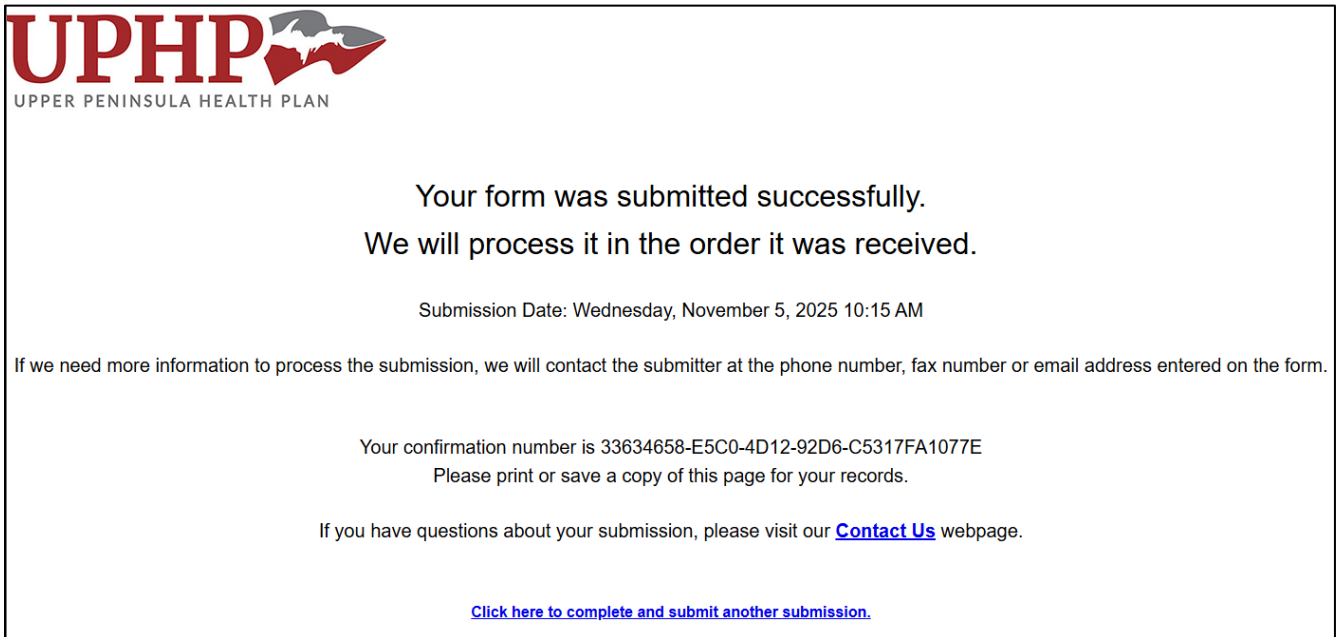
8. Submit the form after filling in all fields and attaching documents.



While the form is submitting a loading image may appear:




9. Once the form is submitted, you will see a success page as shown below.



## Utilization Management (UM): Submit Medical Records

This form can be used to submit medical records to the UPHP UM team.

1. Enter the UPHP member's information.

| Member Information   |                          |
|--|--------------------------|
| <b>Member First Name:</b>  | <b>Member Last Name:</b> |
| <input type="text"/>   | <input type="text"/>     |
| <b>Member Date of Birth:</b>   | <b>Member ID:</b>        |
| <input type="text"/>  | <input type="text"/>     |

2. Select the UPHP member's current health plan – Medicaid or Medicare.

| Member's Health Plan:   |
|---|
| <input type="radio"/> The member is enrolled in UPHP Medicaid, Healthy Michigan Plan (HMP) or Children's Special Health Care Services (CSHCS) |
| <input type="radio"/> The member is enrolled in UPHP MI Health Link (MHL)   |

3. Select who is submitting the form.

| Submitter Information  |
|--|
| <b>Who is submitting this form?</b>  |
| <input type="radio"/> I am a UPHP Member   |
| <input type="radio"/> I am a UPHP Member's Authorized Representative or Legal Guardian |
| <input type="radio"/> I am a Provider  |

4. Enter your contact information in the Submitter Information fields.
  - a. Call Back Extension is optional.
  - b. A Fax Number OR Email Address must be entered.

|                              |                             |
|------------------------------|-----------------------------|
| <b>Submitter First Name:</b> | <b>Submitter Last Name:</b> |
| <input type="text"/>         | <input type="text"/>        |
| <b>Call Back Number:</b>     | <b>Call Back Extension:</b> |
| <input type="text"/>         | <input type="text"/>        |
| <b>Fax Number:</b>           | <b>Email Address:</b>       |
| <input type="text"/>         | <input type="text"/>        |

5. If someone at UPHP asked you to submit this form, pick yes for the question below and enter their first name and last name or initial.

Did someone from UPHP ask you to submit this request?

Please enter their name:

| First Name                        | Last Name/Initial                |
|-----------------------------------|----------------------------------|
| <input type="text" value="JANE"/> | <input type="text" value="DOE"/> |

6. Enter the reason for submitting the records to UPHP in the Reason for Submission text box.

Reason for Submission:

Sample: Submitting medical records to support a prior authorization request submitted in the UPHP Assist Portal.

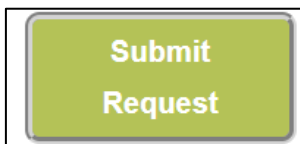
7. Use the Choose File button to attach documents. Some examples are medical records, prescriptions, orders, test results, receipts, or letters. The form will accept PDF's, images, Word documents, and text files. More than one document can be attached.

**Attach Documents**

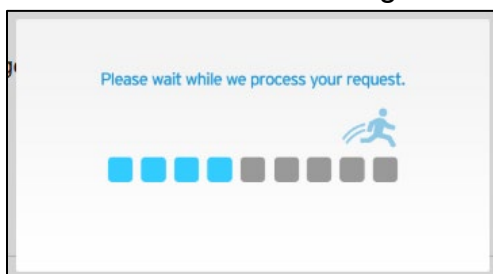
Please attach documents you have to support the request. Some examples are medical records, prescriptions, orders, test results, receipts, or letters.

No file chosen

8. Submit the form after filling in all fields and attaching documents.



While the form is submitting a loading image may appear:



9. Once the form is submitted, you will see a success page as shown below.



Your form was submitted successfully.  
We will process it in the order it was received.

Submission Date: Wednesday, November 5, 2025 10:15 AM

If we need more information to process the submission, we will contact the submitter at the phone number, fax number or email address entered on the form.

Your confirmation number is 33634658-E5C0-4D12-92D6-C5317FA1077E  
Please print or save a copy of this page for your records.

If you have questions about your submission, please visit our [Contact Us](#) webpage.

[Click here to complete and submit another submission.](#)

## Utilization Management (UM): Submit a Prior Authorization Request

Instructions will appear below the Form Type when this option is picked.

There are links to PDF forms that will help the UPHP UM team process your request faster. These forms have fields to collect information we need. Please complete the appropriate PDF form and attach it to the request before submitting.

- **In-Network Providers** – Must use the UPHP Assist Portal to request prior authorization.
- **Out-of-Network Providers** – Please complete the UPHP Medical Prior Authorization Request Form or the UPHP DME/Medical Supply Prior Authorization Request Form.
- **Members** - Please complete the UPHP Coverage Determination Request Form.

### Form Type:

Submit a Prior Authorization (PA) Request ▾

- If you are a Medicaid, Healthy Michigan Plan (HMP) or Children's Special Health Care Services (CSHCS) member, you must have your provider ask for prior authorization for you.
- If you are an Upper Peninsula Health Plan (UPHP) MI Health Link (Medicare-Medicaid) Plan member, please complete the [UPHP Coverage Determination Request Form](#).
- Providers that are in-network with UPHP must use the [UPHP Assist Portal](#) to ask for prior authorization.
- If you are an out-of-network provider, please complete the [UPHP Medical Prior Authorization Request Form](#) or [UPHP DME/Medical Supply Prior Authorization Request Form](#).

### 1. Select the Urgency of Request.

- a. Select Expedited (Fast) if the member's life or health are at risk.

**Urgency of Request** - Select 'Expedited (Fast)' if the standard time frame could be a serious threat to the member's life or health. Otherwise, use 'Standard'.

Select Urgency ▾  
Standard  
Expedited (Fast)

### 2. Enter the UPHP member's information.

| Member Information                                   |  |
|--|--|
| <b>Member First Name:</b><br><input type="text"/>    | <b>Member Last Name:</b><br><input type="text"/> |
| <b>Member Date of Birth:</b><br><input type="text"/> | <b>Member ID:</b><br><input type="text"/>        |

3. Select the UPHP member's current health plan – Medicaid or Medicare.
  - a. Selecting the Medicaid option will only allow a provider to submit the request.
  - b. Members can only request their own prior authorization if they are enrolled in MI Health Link.

|   |
|---|
| <p><b>Member's Health Plan:</b></p> <p><input type="radio"/> The member is enrolled in UPHP Medicaid, Healthy Michigan Plan (HMP) or Children's Special Health Care Services (CSHCS)</p> <p><input type="radio"/> The member is enrolled in UPHP MI Health Link (MHL)</p> |
|---|

4. Select who is submitting the form.

|   |
|---|
| <p><b>Submitter Information</b></p> <p><b>Who is submitting this form?</b></p> <p><input type="radio"/> I am a UPHP Member</p> <p><input type="radio"/> I am a UPHP Member's Authorized Representative or Legal Guardian</p> <p><input type="radio"/> I am a Provider</p> |
|---|

5. Enter your contact information in the Submitter Information fields.
  - a. Call Back Extension is optional.
  - b. A Fax Number OR Email Address must be entered.

|                              |                      |                             |                      |
|------------------------------|----------------------|-----------------------------|----------------------|
| <b>Submitter First Name:</b> | <input type="text"/> | <b>Submitter Last Name:</b> | <input type="text"/> |
| <b>Call Back Number:</b>     | <input type="text"/> | <b>Call Back Extension:</b> | <input type="text"/> |
| <b>Fax Number:</b>           | <input type="text"/> | <b>Email Address:</b>       | <input type="text"/> |

6. If someone at UPHP asked you to submit this form, pick yes for the question below and enter their first name and last name or initial.

|  |                                   |                                  |
|--|-----------------------------------|----------------------------------|
| Did someone from UPHP ask you to submit this request? <input type="button" value="YES"/> |                                   |                                  |
|  | <b>First Name</b>                 | <b>Last Name/Initial</b>         |
| Please enter their name:   | <input type="text" value="JANE"/> | <input type="text" value="DOE"/> |

7. Enter the reason for submitting the records to UPHP in the Reason for Submission text box.

Reason for Submission:

Sample: Submitting medical records to support a prior authorization request submitted in the UPHP Assist Portal.

8. Use the Choose File button to attach documents. Some examples are medical records, prescriptions, orders, test results, receipts, or letters. The form will accept PDF's, images, Word documents, and text files. More than one document can be attached.

**Attach Documents**

Please attach documents you have to support the request. Some examples are medical records, prescriptions, orders, test results, receipts, or letters.

No file chosen

9. Read the Submission Attestation.

- a. Check the first box to attest that you have attached information about what you are asking for.
- b. Check the second box to attest that you have attached documents to support your request.

**Submission Attestation**

I have attached information about the requested service(s).

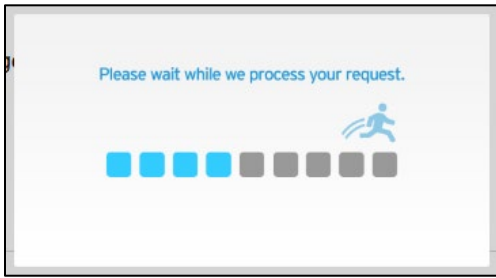
Providers: [UPHP Medical Prior Authorization Request Form](#), [UPHP DME/Medical Supply Prior Authorization Request Form](#) or equivalent (one like it)

UPHP MI Health Link (MHL) Members: [UPHP Coverage Determination Request Form](#) or equivalent (one like it)

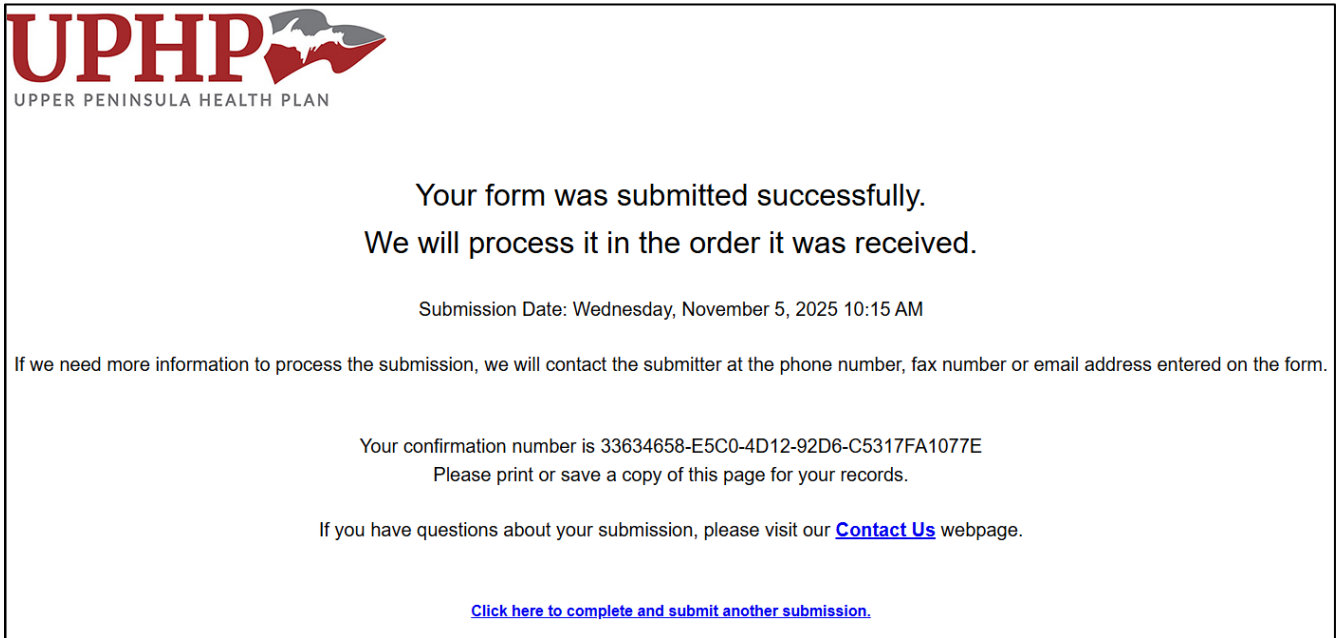
I have attached documents to support the request.

10. Submit the form after filling in all fields and attaching documents.

While the form is submitting a loading image may appear:



11. Once the form is submitted, you will see a success page as shown below.



## Utilization Management (UM): Submit a Hospital or Skilled Care Notification

**UPHP members cannot submit this form. This option is only for providers.**

- There is a link to a skilled nursing facility notification PDF form that will help the UPHP UM team process your request faster. These forms have fields to collect information we need. Please complete the fillable PDF form and attach it to the request before submitting.
- For hospital inpatient and observation admissions, there is no additional UPHP form required for submission. Only clinical documents need to be submitted.


**Form Type:**  
Submit a Hospital or Skilled Care Notification ▾

- This form can only be submitted by providers.
- If you need to tell us about Skilled Care, please complete the [UPHP Skilled Care Notification and Update Form](#).
- If you need to tell us about a hospital admission or discharge, please attach records to support the notification. You can also send us updates about a member's hospital admission.

1. Enter the UPHP member's information.

**Member Information**

**Member First Name:**  **Member Last Name:**

**Member Date of Birth:**   **Member ID:**

2. Select the UPHP member's current health plan – Medicaid or Medicare.

**Member's Health Plan:**

The member is enrolled in UPHP Medicaid, Healthy Michigan Plan (HMP) or Children's Special Health Care Services (CSHCS)

The member is enrolled in UPHP MI Health Link (MHL)

3. Select who is submitting the form.

**Submitter Information**

**Who is submitting this form?**

I am a UPHP Member

I am a UPHP Member's Authorized Representative or Legal Guardian

I am a Provider

4. Enter your contact information in the Submitter Information fields.
  - a. Call Back Extension is optional.
  - b. A Fax Number OR Email Address must be entered.

|  |   |
|--|---|
| <b>Submitter First Name:</b><br><input style="width: 95%;" type="text"/> | <b>Submitter Last Name:</b><br><input style="width: 95%;" type="text"/> |
| <b>Call Back Number:</b><br><input style="width: 95%;" type="text"/>     | <b>Call Back Extension:</b><br><input style="width: 95%;" type="text"/> |
| <b>Fax Number:</b><br><input style="width: 95%;" type="text"/>           | <b>Email Address:</b><br><input style="width: 95%;" type="text"/>       |

5. If someone at UPHP asked you to submit this form, pick yes for the question below and enter their first name and last name or initial.

|   |   |  |
|---|---|--|
| Did someone from UPHP ask you to submit this request? <span style="border: 1px solid black; padding: 2px;">YES ▾</span> |   |  |
|   | <b>First Name</b>                                     | <b>Last Name/Initial</b>                             |
| Please enter their name:  | <input style="width: 95%;" type="text" value="JANE"/> | <input style="width: 95%;" type="text" value="DOE"/> |

6. Enter the reason for submitting the notification to UPHP in the Reason for Submission text box.

|  |
|--|
| <b>Reason for Submission:</b>  |
| Sample: Submitting a notification of member inpatient admission to <facility> on <admit date>. |

7. Use the Choose File button to attach documents. Some examples are medical records, prescriptions, orders, test results, receipts, or letters. The form will accept PDF's, images, Word documents, and text files. More than one document can be attached.

|   |
|---|
| <p><b>Attach Documents</b></p> <p>Please attach documents you have to support the request. Some examples are medical records, prescriptions, orders, test results, receipts, or letters.</p> <div style="margin-top: 10px;"> <input type="button" value="Choose File"/> No file chosen         </div> |
|---|

8. Read the Submission Attestation.

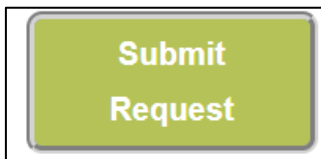
- a. Check the first box if you are submitting a skilled care notification or update to attest that you have attached information about what you are asking for; OR
- b. Check the second box if you are submitting a hospital notification to attest that you have attached documents to support your request.

**Submission Attestation**

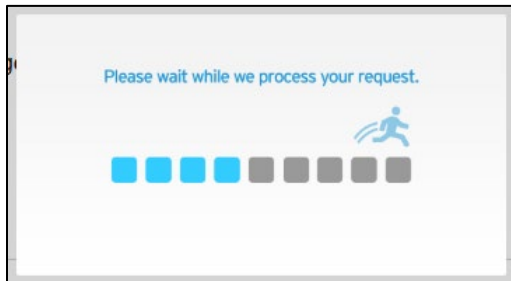
I am submitting a Skilled Care notification or update. I have attached the [UPHP Skilled Care Notification and Update Form](#).

I am submitting a hospital notification. I have attached documents to support the request.

9. Submit the form after filling in all fields and attaching documents.



While the form is submitting a loading image may appear:



10. Once the form is submitted, you will see a success page as shown below.

