

UM Department Phone #: 855-429-1028 Behavioral Health/IDD UM Fax #: 800-886-6839

**USE THIS FORM TO REQUEST SERVICES SPECIFIC FOR BEHAVIORAL HEALTH OR DEVELOPMENTAL DISABILITY PROVIDERS		
Requestor's Contact Name: Requestor's Contact #:		
Patient Information:		
*Name: *DOB:		
*Patient ID #:	*Patient Phone #:	
	ective / Routine	
Note: Selected Expedited/ Urgent to prevent serious deterioration in health or jeopardize ability to regain maximum function.		
(For Claim Denial or Prior Authorization Denial, please submit an Appeal through Customer Service at 1-855-429-1028)		
*Service Type Requested: Please review plans benefit prior to request		
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Behavioral Health	Intellectual/Developmental Disability	Other
☐ Acute		
☐ Psychiatric residential	□ ICF	
treatment		
☐ Outpatient behavioral	☐ Outpatient	
health		
☐ Concurrent Review	☐ Other	
□ Other		
Always verify eligibility, benefits and prior authorization requirements		
Procedure Information:		
*ICD 10 Diagnosis: Diagnosis Description:		
*CPT/HCPC Code & Description (Include Unit of Measure / Frequency for supplies):		
*Date(s) of Service: # of Units or Visits:		
Provider Information:		
Requesting P	<b>Provider</b> Is this the patient's Primary Care Ph	ysician?
*Name:	*NPI	TIN:
*Phone:	*Fax	
*Address:		
Rendering Provider		
If Requesting and Rendering providers o		***************************************
*Name:	*NPI	*TIN:
*Phone:	*Fax	
*Address:		
Facility	□ N/A	
*Name:	*NPI	*TIN:
*Phone:	*Fax	
*Address:		
Request for extension to existing authorization number:		
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PLEASE COMPETE ALL SECTIONS WITH AN ASTERISK (*) <u>AND</u> ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NECESSITY. INCOMPLETE INFORMATION MAY DELAY THE PROCESS.		

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time of services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per

Plan policy and procedures.

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