empower HEALTHCARE SOLUTIONS

UM Department Phone #: 855-429-1028
Medical UM Fax #: 800-878-8264

Requestor's Contact Name: Requestor's Contact #:

Patient Information:

*Name: *DOB:

*Patient ID #: *Patient Phone #:

*Service Is: ☐ Elective / Routine ☐ Expedited / Urgent

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

Inpatient	Outpatient	Other
☐ Emergent Inpatient	☐ Surgical Procedure	☐ Home Health /Skilled Services
☐ Concurrent Review	☐ Physical Therapy	☐ Home Infusion/ IVT
☐ Observation Stay >48 hrs	☐ Occupational Therapy	☐ Private Duty Nursing
☐ Surgical Procedures	☐ Speech Therapy	☐ DME
☐ Elective Admission	☐ Chiropractic Services	☐ Prosthetics/Orthotics
☐ Skilled Nursing Facility	☐ Chemotherapy	☐ Allergy Testing (Ages 4 and under)
☐ Long-Term Acute Care	☐ Imaging	☐ Cosmetic Procedure
☐ Acute Rehab	☐ Sleep Study (facility based)	☐ Air Ambulance
☐ Maternity	☐ Pain Management	☐ DNA/Genetic Testing
☐ NICU Stay	☐ High Cost Medication >$1000 (administered in office)	☐ Other: _____
☐ Transplant	☐ Bariatric Procedure	
☐ Bariatric Procedure		

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 Provider Is this the patient's Primary Care Physician? ☐ Yes ☐ No

*Name: *NPI TIN:

*Phone: *Fax

*Address:

Rendering Provider ☐ Same as the Requesting Provider

If Requesting and Rendering providers differ, complete section below

*Name: *NPI *TIN:

*Phone: *Fax

*Address:

Facility ☐ N/A

*Name: *NPI *TIN:

*Phone: *Fax

*Address:

Request for extension to existing authorization number:

Always verify eligibility, benefits and prior authorization requirements

PLEASE COMPETE ALL SECTIONS WITH AN ASTERISK (*) AND ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NECESSITY. INCOMPLETE INFORMATION MAY DELAY THE PROCESS.