UnitedHealthcare Community Plan

PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date:		
SECTION A - PATIENT INFORMATION		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW ☐ or a CONTINUATION of THERAPY ☐? If so, start date:_____

Is this patient currently hospitalized? ☐ Yes ☐ No

SECTION B - PHYSICIAN INFORMATION				
First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

SECTION C - MEDICAL INFORMATION	
Medication:	**Strength:**
Directions for use:	
Diagnosis (Please be specific & provide as much information as possible)**:** ☐ Check here if member has diagnosis of HIV/AIDS	**ICD-9 CODE:**
Is this member pregnant? ☐ Yes ☐ No If yes, what is this member's due date?	
Explanation of why the preferred medication(s) would not meet your patient's needs (Additional documentation may be faxed with this form to assist with the determination of medical necessity):	

Other Medications Tried

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Physician Signature: _____ **Date:** _____