

Instructions:

- Please complete the form located on page two. Fields with an asterisk (*) are required.
- Please include all clinical information, x-ray reports, and diagnostic test results supportive of the procedure(s) requested

You now have several options for submitting your Prior Authorization requests to OptumCare:

- If you have your own secure system, please submit authorization requests to: **LCD_UM@optum.com**
- If you do not have a secure email in place, please contact our service center at 1-877-370-2845. We will ask for your email address and will send a secure email for Prior Authorization requests to be sent to our office.
- You can fax your requests to **1-888-992-2809**
- Or mail the completed form to:

OptumCare
Attention: Prior Authorization
PO Box 46770
Las Vegas, NV 89114-6770



PRIOR AUTHORIZATION FORM

Phone: (877) 370-2845 opt 2

Fax: (888) 992-2809

PLEASE MARK ONE OF THE FOLLOWING:

- ROUTINE (Normal, non-urgent request)
- DATE SENSITIVE (Date Sensitive is defined as an upcoming date of service)
- URGENT (Urgent is defined as significant impact to health of the member if not completed within 72 hours)

PATIENT INFORMATION:

LAST NAME: _____ FIRST NAME: _____ DOB: _____
PHONE: _____ INSURED ID: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

REQUESTING PROVIDER INFORMATION:

PROVIDER NAME: _____
GROUP NAME: _____
SPECIALTY: _____
TAX ID #: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
CONTACT NAME: _____
PHONE: _____ EXT: _____
FAX: _____

PLACE OF SERVICE INFORMATION:

PROVIDER/FACILITY: _____
GROUP NAME: _____
SPECIALTY: _____
TAX ID #: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
CONTACT NAME: _____
PHONE: _____ EXT: _____
FAX: _____

SERVICES: DOS: _____ DME ITEMS (CHECK ONE): RENTAL PURCHASE

TYPE OF SERVICE: OUTPT INPT Office Surgery Ctr SNF Home Other: _____

DIAGNOSIS CODE(S): _____

CPT/HCPCS CODE(S) (INCLUDE NUMBER OF UNITS PER CODE): _____

• PLEASE ATTACH SUPPORTING CLINICAL INFORMATION (E.G., PLAN OF CARE, MEDICAL RECORDS, LAB REPORTS, LETTER OF MEDICAL NECESSITY, PROGRESS NOTES, ETC.)

- ALL SECTIONS OF THIS FORM MUST BE COMPLETED.
- ON ADVERSE DETERMINATIONS, A RECONSIDERATION/EXPEDITED APPEAL MAY BE REQUESTED.

This referral/authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, and other terms & conditions set forth in the member's Evidence of Coverage.

The information contained in this form, including attachments, is privileged and confidential & is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or the agent responsible to deliver to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.