OPTUM Care™

PRIOR AUTHORIZATION FORM
Phone: (877) 370-2845 opt 2
Fax: (888) 992-2809

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

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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.