UnitedHealthcare Community Plan

PRIOR AUTHORIZATION REQUEST FORM

Please complete this entire form and fax to: **1-844-881-4926.** If you have questions, please call **1-866-331-2243**

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 □ Continuation of Therapy? If continuation: list 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:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 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)

Section D – Previous Medication Trials

Medications	**Strength**	**Directions**	**Dates of Therapy**	**Reason for failure / discontinuation**

Physician Signature: _____ **Date:** _____