UnitedHealthcare Community Plan

UnitedHealthcare Community Plan
Phone: 1-888-980-8728
Fax: 1-877-840-5581

Hawaii Medicare Dual & QUEST Members ONLY

BEHAVIORAL HEALTH AUTHORIZATION REQUEST FORM

Today's Date: ______________________ URGENT: ☐ Yes ☐ No

MEMBER INFORMATION

Member Name: ______________________ DOB: ______________________

Home Address: ______________________ Gender: ______________________

City State, and ZIP Code: ______________________ Phone: ______________________

INSURANCE INFORMATION

QUEST Integration Plan: ______________________ QUEST ID #: ______________________

Medicare Plan: ______________________ Medicare ID #: ______________________

Other Insurance: ______________________ Other Plan ID #: ______________________

SERVICING PROVIDER INFORMATION

Facility Name: ______________________ Service Setting: ______________________

Clinician Name: ______________________ Phone: ______________________

Provider Address: ______________________ Fax: ______________________

Office Contact Name: ______________________ Tax ID #: ______________________

CLINICAL

For requests for continuation of services, send initial and / or updated evaluation and progress notes along with servicing provider's signature. For psychological testing requests, please indicate which tests you plan to administer. For methadone maintenance requests, please include U/A results.

Date(s) of Service, From ______________________ To: ______________________

Additional Information: ______________________

ICD-10-CM CODE(S)	DIAGNOSES

CPT / HCPC CODE(S)	PROCEDURE(S) / TREATMENT(S)	# OF VISIT(S) or UNIT(S)