

## REQUEST FOR REFERRAL TO SPECIALIST or TELEHEALTH

Call UM at 844-206-3719 (Call Center Hours M-F 8a- 8p)

FAX Form and Clinical to 833-610-2399

**\*\*\* PLEASE DO NOT SEND REQUESTS FOR MULTIPLE MEMBERS TOGETHER IN ONE FAX – MUST SEND SEPARATELY**

**\*PRIOR AUTHORIZATION IS REQUIRED FOR SERVICES BY ANY NON-PARTICIPATING PROVIDER. (ATTACH OON FORM)** Payment is authorized only for the medical services noted below, and is subject to the limitations and exclusions as outlined in the Member Handbook/Certificate of Coverage.

<b>Member Data</b>	Member Name _____	Date of Birth _____	Member's Plan ID _____
	Name of Nursing Facility _____	Referring Provider _____	Is Referring Provider: <input type="checkbox"/> Plan NP <input type="checkbox"/> PCP <input type="checkbox"/> Plan PA <input type="checkbox"/> Other
	Diagnoses (ICD-10 Codes) Related to Auth Request _____		
<b>Service</b>	Date of Procedure/Service: _____ CPT Code or Name of Procedure/Service: _____		

### SERVICES REQUESTED

(Include copy of order or clinical note for out-of-network requests) **(ATTACH OON FORM)**

<b>Specialist</b>	Provider Name (REQUIRED): _____		
	Provider Contact Number (REQUIRED): _____		
	Provider Specialty (REQUIRED): _____		
	In Network (REQUIRED): Circle Correct Answer:      YES                      NO		
<b>Telehealth</b>	Vendor Name (REQUIRED): _____		
	Vendor Contact Number (REQUIRED): _____		
	Specialty (REQUIRED): _____		
	In Network (REQUIRED): Circle Correct Answer:      YES                      NO		

### TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

Name of Person Completing this Form: \_\_\_\_\_ Date Completed: \_\_\_\_\_  
 (Please Print Name)

Contact #: \_\_\_\_\_ Contact FAX: \_\_\_\_\_