



PRIOR AUTHORIZATION FORM

AZ/UT Phone: 1-877-370-2845 opt 2

NV Phone: 1-855-893-2297 opt 2

Fax: 1-888-992-2809

Instructions:

- Please complete the form located on page two. Fields with an asterisk (*) are required.

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**
- You can fax your requests to **1-888-992-2809**
- Or mail the completed form to: **OptumCare
Attention: Prior Authorization
PO Box 30539
Salt Lake City, UT 84130**



PLEASE MARK ONE OF THE FOLLOWING:
 ROUTINE (Normal, non-urgent request)
 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: _____
 TYPE OF SERVICE: OUTPT INPT Office Surgery Ctr SNF Home Other: _____
 DIAGNOSIS CODE(S): _____
 CPT/HCPCS CODE(S) (INCLUDE NUMBER OF UNITS PER CODE): _____

 DME ITEMS (CHECK ONE): RENTAL PURCHASE Cost: _____

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

This 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.

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