PEOPLES HEALTH

A UnitedHealthcare Company

MEDICAL NECESSITY FORM

Date of Request: ____/____/____ (MM DD YYYY)

You can also submit a request via the UnitedHealthcare Provider Portal at www.uhcprovider.com.

To confirm authorization requirements for Peoples Health patients, visit www.uhcprovider.com/priorauth. In the Medical Professional Resources section, select **Advance notification**, then open the following drop-down menu: **UnitedHealthcare Medicare Advantage, UnitedHealthcare West Medicare Advantage, UnitedHealthcare Dual Complete / Peoples Health Prior Authorization Requirements**. Click the file linked under Current Prior Authorization Requirements to review codes that require prior authorization.†

SERVICE REQUESTED (SIGNED PHYSICIAN ORDER AND CLINICAL NOTES REQUIRED FOR ALL REQUESTS):

- ❑ SURGERY/PROCEDURE
  - ❑ Inpatient
  - ❑ Outpatient
  - ❑ Office
  - ❑ ASC
- ❑ HOME HEALTH
- ❑ DME
- ❑ OUTPATIENT THERAPY
- ❑ OUTPATIENT DIAGNOSTIC TESTS
- ❑ LEVEL OF CARE CHANGE
- ❑ DISCHARGE ORDERS
- ❑ INPATIENT ADMISSION
- ❑ OTHER

FAX STANDARD, ADMISSION, LEVEL OF CARE CHANGE, DISCHARGE ORDER, UPDATED AND PRIORITY FORMS TO 1-866-464-5709.

Note: Retroactive requests are not eligible for medical necessity review and authorization, except for home health and DME when submitted within two days of initiation of services.

CONFIDENTIAL HEALTH INFORMATION

This message, including attachments, may include confidential and/or proprietary information, and may be used only by the person or entity to which it is addressed. If the reader of this message is not the intended recipient or his or her authorized agent, the reader is hereby notified that any dissemination, distribution or copying of this message is prohibited. If you have received this message in error, please notify the sender by replying to this message and destroy this message immediately.

This certification is based upon medical necessity and eligibility and is not a guarantee of payment.

In compliance with HIPAA Privacy Regulations Code Section 164.530 (c) (2): to safeguard protected health information

†If your contract with Peoples Health specifies that different or additional services than those listed in this document require medical necessity review, your contract preempts this list.

Choose the appropriate option:

❑ **STANDARD:** Requests not requiring prioritization (decision made ASAP but no later than 15 days)

❑ **ADMISSION, LEVEL OF CARE CHANGE OR DISCHARGE ORDER:** Requests will be reviewed promptly; call to provide notification: **1-877-346-5707**

❑ **CLINICAL UPDATE/ADDITIONAL INFORMATION:** Request changes to or provide additional information for a submitted request, including date of service or procedure code changes

If request requires prioritization because service is scheduled or needs to be scheduled within two to seven business days, check here ❑

If request is medically urgent and a delay of more than three days could put patient's life, health or ability to regain maximum function in serious jeopardy, and provider believes request should be expedited, check here ❑ and fax form to **1-866-799-5713**.

Provide any additional information: _____

_____

Must submit only documentation pertaining to the service(s) listed on this form.

Support Documentation: Check all that apply for the service(s) listed (signed physician order and clinical notes, including a diagnosis that supports your request, are required for all services).

All applicable boxes and fields must be checked/completed. Incomplete forms delay processing.

❑ Clinical Notes ❑ Diagnostic Tests ❑ Signed Physician Order
❑ Medications ❑ Laboratory Results ❑ Other: _____

Date of Service:

Service scheduled? ❑ Yes ❑ No Scheduled/anticipated date: ____/____/____ (MM DD YYYY)

Patient Information:

Plan Member ID # _____

Patient Name _____ Date of Birth ____/____/____ (MM DD YYYY)

Additional Information: *Height* _____ *Weight* _____ *BMI* _____

Requesting Provider:

Name _____ Specialty _____

Office Contact _____

Phone _____ Fax _____

Servicing Provider:

Name _____ Specialty _____

Office Contact _____

Phone _____ Fax _____

Place of Service (facility name, DME vendor, etc.) _____

ICD Diagnosis Code(s) _____

Service(s) Requested _____

Procedure Code(s) CPT-4 _____

Describe Medical Necessity of Service(s) _____

_____