UCLA Health | Medicare ADVANTAGE PLAN

Prior-Authorization Request Form

Fax: **1(424) 234-7698** *Telephone*: **1 (833) 627-8252**
Email: **HPUM@mednet.ucla.edu**

Date request submitted:

Request Priority	☐ **Pre-Service**	☐ **Post-Service**
☐ Routine	☐ Retro	☐ Urgent

If urgent review is requested, the member must have a health condition that may seriously jeopardize their life or ability to regain maximum function. Please provide explanation of exigency ***(required if urgent review requested)****:*

Referral Reason

☐ Transplant Evaluation	☐ Long Term Acute Care Hospital (*LTACH*)
☐ Transplant Procedure	☐ Acute Rehab (*IRF*)
☐ Hospital Admission (*Inpatient*)	☐ Other:
☐ Skilled Nursing Facility (*SNF*)	

Date

Dates of service for which authorization is requested(*mm/dd/yyyy*):

Patient Information

Member Name (Last, First, MI):	Member Date of Birth (*mm/dd/yyyy*):
Member Phone Number:	Address (Street, City, ZIP):
Medicare ID Number:	Health Plan ID#:

Requesting Provider	**Rendering Provider**
☐ Primary Care Provider ☐ Specialist ☐ Facility	☐ Name ☐ Facility ☐ Vendor
Name of Provider:	Name of Provider:
Provider NPI#:	Provider NPI#:
Provider Phone Number:	Provider Phone Number:
Provider Fax Number:	Provider Fax Number:
Contact Name:	Contact Name:
Provider Address:	Provider Address:

Requested ICD 10 Code/s

CODE	MODIFIER	QUANTITY	DIAGNOSIS

Requested CPT Code/s

CODE	MODIFIER	QUANTITY	DESCRIPTION

If additional ICD 10 and/or CPT code(s) are requested, please attach document:

Authorizations

Authorizations are based on medical necessity and covered services. Authorizations are contingent upon member's eligibility and benefits and are not a guarantee of payment.