# Prior-Authorization and Exception Request Form

UCLA Health | Medicare ADVANTAGE PLAN

Fax: **1(424) 234-7698** Telephone: **1 (833) 627-8252**

**NOTE: ALL FIELDS MARKED WITH AN ASTERISK (*) ARE REQUIRED.**

**TYPED ONLY - NO HANDWRITTEN FORMS**

Select all that apply*: ☐New Request ☐ Modify Auth #: ☐Second Opinion ☐Experimental (Not a benefit)

Select priority*: ☐Routine ☐Retro (Must be submitted within 30 calendar days of date of service)

Urgent (Select reason): ☐Transplant Evaluation ☐Transplant Procedure ☐Hospital Discharge

☐Inpatient Hospice ☐Enteral Nutrition ☐Investigational/Clinical Trial Services

☐Other Urgent: Member's life, health, or ability to attain, maintain, or regain max function in serious jeopardy

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. The provider is responsible for verifying a member's eligibility on the date of service. Please verify eligibility using one of the following methods:

1. Web: **UCLAHealthMedicareAdvantage.org/forproviders** 2. Member Services: **1(833) 627-8252**

Plan name: ☐Principal ☐Prestige

Does additional coverage exist? * ☐Yes ☐No

If yes, specify the following: Carrier: Policy#:

| **PATIENT** | **REQUESTING PROVIDER** |
|---|---|
| Name*: | ☐Primary Care Provider ☐Specialist ☐Vendor/Ancillary |
| Member ID#*: Date of Birth*: | Name*: |
| Telephone*: | Telephone*: Fax: |
| Address*: | Contact Name: Address: |

**RENDERING PROVIDER**

Name / Facility / Vendor*:

| | |
|---|---|
| Specialty*: NPI#: | Reason for out of medical group/non-contracted provider: |
| Telephone*: Fax*: | |
| Contact Name: | |
| Address: | |

**CLINICAL JUSTIFICATION / MEDICAL NECESSITY**

## DIAGNOSES / ICD 10 CODES

At least one valid diagnosis code **and** one valid service code are required. *

**Diagnosis /ICD 10 Codes:** Please document diagnosis and or ICD 10 codes completely.

Service Codes: Indicate quantity and modifiers (if applicable) for each code. If no quantity is indicated, the amount will default to 1. Ensure quantities are consistent with valid CPT/HCPCS values.

| CODE | MOD | QTY | DESCRIPTION | CODE | MOD | QTY | DESCRIPTION |
|---|---|---|---|---|---|---|---|
| 1234 | | | | | | | |
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Select hospital status*: ☐Inpatient ☐Outpatient/Observation

Date of service:

Comments:

Today's Date: