Instructions:

- Please complete the form located on page 2. Fields with an asterisk (*) are required. If mandatory fields are not complete, information will not be accepted and processed.

You now have several options for submitting your Prior Authorization requests to OptumCare:

- Online (preferred method): **professionals.optumcare.com/portal-login**

- Fax for **NY** market (only if online option is not available)
  Fax the completed form to: **OptumCare**

  Regular Prior Authorization: **1-855-248-4063**
  Part B/Expedited Requests Fax: **1-855-244-8503**
  Medical Records or Clinicals: **1-877-940-3604**

- Phone (only if online & fax options are not available)
  NY Phone: **1-866-565-3468**

All referrals should be submitted through the provider portal at
professionals.optumcare.com/portal-login

The paper form is available for use on an exception basis. If paper form is used, please complete the form located on page 2. All fields are required. Any forms with required fields missing information will be faxed back and identified as unable to process.

OPTUM Care®

PRIOR AUTHORIZATION FORM

professionals.optumcare.com/portal-login

PLEASE MARK ONE OF THE FOLLOWING:

□ ROUTINE (Normal, non-urgent request completed within 14 days.)

□ URGENT (Urgent is defined as significant impact to health of the member if not completed within 72 hours per the requesting physician. A signed physician order and clinicals must be included.)

PATIENT INFORMATION:

LAST NAME*:_____ FIRST NAME*:_____ DOB*:_____

PHONE*:_____ INSURED ID*: _____

ADDRESS*:_____ CITY*:_____ STATE*:_____ ZIP*: _____

REQUESTING PROVIDER INFORMATION:

PROVIDER NAME*:_____

GROUP NAME:_____

SPECIALTY*:_____

TAX ID or NPI #*:_____

ADDRESS*: _____

CITY*:_____ STATE*:_____ ZIP*:_____

CONTACT NAME*:_____

PHONE*:_____ EXT:_____

FAX*: _____

SERVICING PROVIDER:

PROVIDER/FACILITY NAME*:_____

GROUP NAME: _____

SPECIALTY*:_____

TAX ID or NPI #*: _____

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)*: _____ _____ _____

_____ _____ _____ _____ _____ _____ _____ _____ _____

FOR 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.

The information contained in this form, including attachments, is privileged and confidential & is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or the agent responsible to deliver to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.

rev date: 11/21