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**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](https://professionals.optumcare.com/portal-login)
- Fax for **IN** 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)  
IN Phone: **1-866-565-3361**

All referrals should be submitted through the provider portal at  
[professionals.optumcare.com/portal-login](https://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.

**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:**

PROVIDERNAME\*: \_\_\_\_\_  
 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.

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