



REQUEST FOR REFERRAL TO SPECIALIST & TELEHEALTH

Call UM at: 1-844-788-6959 (TTY 711) for CO or 1-844-788-6986 (TTY 711) for OH (Call Center Hours M-F 8a– 8p)

FAX Form and Clinical to: 1-833-610-2399

***** PLEASE DO NOT SEND REQUESTS FOR MULTIPLE MEMBERS TOGETHER IN ONE FAX – MUST SEND SEPARATELY**

***PRIOR AUTHORIZATION IS REQUIRED FOR SERVICES BY ANY NON-PARTICIPATING PROVIDER. (ATTACH OON FORM)** Payment is authorized only for the medical services noted below, and is subject to the limitations and exclusions as outlined in the Member Handbook/Certificate of Coverage.

Member Data	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; border-bottom: 1px solid black;">Member Name</td> <td style="width: 33%; border-bottom: 1px solid black;">Date of Birth</td> <td style="width: 33%; border-bottom: 1px solid black;">Member's Plan ID</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Name of Nursing Facility</td> <td style="border-bottom: 1px solid black;">Referring Provider</td> <td style="border-bottom: 1px solid black;"> Is referring Provider: Plan NP <input type="checkbox"/> PCP <input type="checkbox"/> Plan PA <input type="checkbox"/> Other </td> </tr> <tr> <td colspan="3" style="border-bottom: 1px solid black;">Diagnoses (ICD-10 Codes) Related to Auth Request _____</td> </tr> </table>	Member Name	Date of Birth	Member's Plan ID	Name of Nursing Facility	Referring Provider	Is referring Provider: Plan NP <input type="checkbox"/> PCP <input type="checkbox"/> Plan PA <input type="checkbox"/> Other	Diagnoses (ICD-10 Codes) Related to Auth Request _____		
Member Name	Date of Birth	Member's Plan ID								
Name of Nursing Facility	Referring Provider	Is referring Provider: Plan NP <input type="checkbox"/> PCP <input type="checkbox"/> Plan PA <input type="checkbox"/> Other								
Diagnoses (ICD-10 Codes) Related to Auth Request _____										
Service	Date of Procedure/Service: _____ CPT Code or Name of Procedure/Service: _____									

SERVICES REQUESTED
 Referral-include copy of order Out of Network- (ATTACH OON FORM)

Specialist/HealthCare Professional	Provider Name (REQUIRED): _____ Provider Contact Number (REQUIRED): _____ Provider Specialty (REQUIRED): _____ In Network (REQUIRED): Circle Correct Answer: YES NO Number of Visits Requested: _____
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Telehealth	Vendor Name (REQUIRED): _____ Vendor Contact Number (REQUIRED): _____ Specialty (REQUIRED): _____ In Network (REQUIRED): Circle Correct Answer: YES NO Number of Visits Requested: _____
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TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

Name of Person Completing this Form: _____ Date Completed: _____
 (Please Print Name)

Contact #: _____ Contact FAX: _____