



**Nevada Standard Prior Authorization Request Form**

Please submit your request online using our Prior Authorization and Notification tool at [www.UHCprovider.com/paan](http://www.UHCprovider.com/paan). You may also initiate your request by phone by calling the number on the back of the member's health plan ID card or by faxing this completed form to 1-855-352-1206.

Section I — Date and Time Submitted: \_\_\_\_\_ a.m. / p.m. ET/MT/CT/PT

**Section II— General Information**

Review Type: Routine    Urgent	Clinical Reason for Urgency
Request Type: <input type="checkbox"/> Initial Request	Extension/Renewal/Amendment (Prev. Auth. #: _____ )

**Section III — Patient Information**

Name	Patient Preferred Phone #	DOB	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Subscriber Name (if different)	Member ID #	Group #	

**Section IV — Provider Information**

<b>Requesting Provider or Facility Name</b>		<b>Service Provider or Facility Name</b>	
NPI # or Tax ID #	Specialty	NPI # or Tax ID #	Specialty
Phone		Phone	
Address		Address	
<b>Name of Primary Care Provider</b>		Phone	

**Section V — Services Requested (with CPT, CDT or HCPCS Code) and Supporting Diagnoses (with ICD-10 Code)**

Planned Service or Procedure	Code(s)	Start Date	End Date	Diagnosis Description	Code(s)
<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Provider Office <input type="checkbox"/> Observation <input type="checkbox"/> Home <input type="checkbox"/> Day Surgery <input type="checkbox"/> Other (specify)					
<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Cardiac Rehab <input type="checkbox"/> Mental Health/Substance Abuse					
Number of sessions	Duration	Frequency	Other		
<input type="checkbox"/> Home Health    MD signed order must be attached to this request. Please also attach the nursing assessment.					
Number of visits requested	Duration	Frequency	Other		
<input type="checkbox"/> Durable Medical Equipment MD signed order must be attached to this request. Equipment/Supplies (Include Any HCPCS Codes)					
					Duration

**Section VI — Clinical Documentation:** Please provide a brief explanation of medical necessity for service(s) and attach supporting clinical documentation with this request.

Please provide contact information in case we need more information.

Name: \_\_\_\_\_ Phone \_\_\_\_\_ (ext. \_\_\_\_\_) email

Preferred method of contact is:  phone  email

**Section VII — Reason for Denial or Partial Denial**

A list of services that require prior authorization is available at [www.UHCprovider.com](http://www.UHCprovider.com)