UNITY HEALTH INSURANCE
PRIOR AUTHORIZATION REQUEST FORM

Fax / Mail Completed Form to:

UW Medical Foundation Medical Management
7974 UW Health Court
Middleton, WI 53562

Phone: 1-888-829-5687 or 1-608-821-4200
Fax: 1-608-821-4207

**Please complete the entire form. Incomplete forms will be returned.

For **Non-Urgent Pre-Service Decisions**: Determinations are made within 15 calendar days of receipt.
For **Post-Service Decisions**: Determinations are made within 30 calendar days of receipt.

Date Requested: _____

PATIENT INFORMATION

Patient Name	DOB	Member Number	Date of Service

REFERRAL INFORMATION

AUTHORIZING/REFERRED FROM:	CLINIC CONTACT: / PHONE NUMBER:
☐ PATIENT'S REQUEST DATE LAST SEEN BY PCP: ____/____/_____	SITE/LOCATION: / FAX:
REFERRED TO:	**CLINIC CONTACT:** / **PHONE NUMBER:**
	SITE/LOCATION: / **FAX:**

SERVICES REQUESTED

Consult Only ☐ **Follow-up** ☐ **DME** ☐ **Lab** ☐ **X-Ray** ☐ **Home Care/Hospice** ☐ **Therapy** ☐ ☐ST ☐PT ☐OT

Primary Diagnosis Code: _____ **Description:** _____

Procedure Code(s): _____ **Description:** _____

Applicable diagnostic testing preformed: _____

☐ **Prior Authorization** **Description:** _____

Surgery ☐**Inpatient** ☐**Outpatient**

Coordination of Benefits ☐ **Yes** ☐ **No** **Date of Injury/Loss** _____
WC ☐ **Yes** ☐ **No**
MVA/Subro ☐ **Yes** ☐ **No** **Date of Injury/Loss** _____
Other Coverage ☐ **Yes** ☐ **No** **Ins. Co.** _____

☐ **Please send consult notes back to referring physician**

COMMENTS (INDICATIONS FOR REFERRAL TO SPECIALIST):

Note: *This referral does not guarantee payment for services. Benefits will be determined in accordance with the policy terms in effect on the date of service. Please refer to the Certificate of Coverage for a complete description of plan benefits, limitations, and exclusions. Call Unity Customer Service at 1-800-362-3310 if you have questions about this referral.*

UWMF Administrative Information **DO NOT WRITE IN THIS AREA**

☐ Approve ☐ Deny ☐ Other Reference # _____ R U E

Begin Date _____ End Date _____ # Visits _____

Comments: _____

UH00266 (revised 03/09)

_____ _____
Medical Director/Designee Signature Date