AGERIGHT ADVANTAGE

REQUEST FOR PRIOR APPROVAL FOR OUT-OF-NETWORK PROVIDER

***Call** UM at 844-854-6885 (Call Center Hours M-F 8a– 8p)* ***FAX** Form and Clinical to 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.** 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

Member Name _____ **Date of Birth** _____ **Member's Plan ID** _____

Name of Nursing Facility _____ **Referring Provider** _____ Is Referring Provider: ☐ Plan NP ☐ PCP ☐ Plan PA ☐ Other

Diagnoses (ICD-10 Codes) Related to Auth Request _____

Service

Date of Procedure/Service: _____ **CPT Code or Name of Procedure/Service:** _____

SERVICES REQUESTED (include copy of order and the clinical notes)

Specialist/Ancillary Provider/Facility

Provider Name (REQUIRED): _____

Provider Contact Number (REQUIRED): _____

Provider Specialty (REQUIRED): _____

In Network (REQUIRED): ☐ **Yes** ☐ **No**

Requesting Provider

1. **Is this member new enrollee with the Plan:** ☐ Yes ☐ No
2. **Has this provider seen this member in the last 30 days:** ☐ Yes ☐ No
3. **Has the service been scheduled already:** ☐ Yes ☐ No
4. **Is this a specialized service that no other provider can render:** ☐ Yes ☐ No
5. **Does the member have an established relationship with the provider that should not be interrupted?** ☐ Yes ☐ No

If Yes, Explain: _____

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

Name of Person Completing this Form: _____ **Date Completed:** _____

(Please Print Name)

Contact #: _____ **Contact FAX:** _____