AGERIGHT ADVANTAGE

REQUEST FOR PRIOR APPROVAL FOR OUT-OF-NETWORK PROVIDER

Call UM at 844-854-6885 opt 3 (Call Center Hours M-F 8a– 5p) *FAX Form and Clinical to 800-503-6095*

****** 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:** ______________