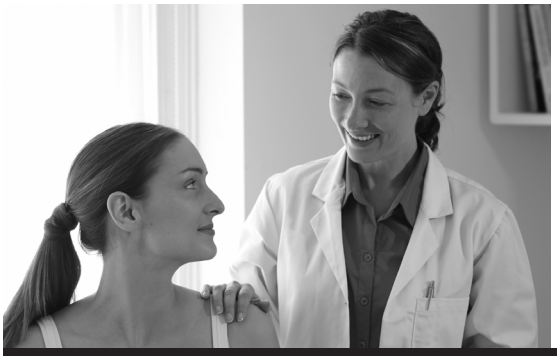

Radiology Notification and Prior Authorization Fax Request Form

This FAX form has been developed to streamline the Notification and Prior Authorization request process, and to give you a response as quickly as possible. Please complete all fields on the form unless otherwise noted.

Please refer to UnitedHealthcare's Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide (the "Guide") for Notification requirements and Prior Authorization requirements. Please note that, as stated in, and in accordance with the Guide, Notification requirements **only** apply to UnitedHealthcare Commercial members and Prior Authorization requirements **only** apply to UnitedHealthcare Medicare Advantage and Medicaid members. Please refer to **www.UnitedHealthcareOnline.com** to see the lists of states in which the Notification requirements for commercial members and the Prior Authorization requirements for Medicare members apply. You may also refer to **www.UnitedHealthcareOnline.com** to see the most current listing of CPT codes that require Notification for Commercial members or Prior Authorization for Medicare Advantage members. Please refer to www.americhoice.com to see the list of the most current CPT codes, by state, that require Prior Authorization for Medicaid members.

Notification program for Commercial

Please note that with respect to the Notification program for Commercial members, this FAX form **must** be signed by the ordering physician.

If the ordering physician does not participate in UnitedHealthcare's commercial network and has not or is unwilling to provide notification, the rendering provider must provide notification by calling **1-866-889-8054.** The rendering provider **cannot** use this FAX form to provide notification.

Prior Authorization program for Medicare

With respect to the Prior Authorization program for Medicare members, this FAX form **must** be signed by the ordering physician. However, if the ordering physician does not participate in UnitedHealthcare's Medicare Advantage network and has not or is unwilling to obtain prior authorization, the rendering provider must obtain prior authorization and may use this FAX form to do so. In that case, this form must be signed by the rendering provider.

Prior Authorization program for Medicaid

With respect to the Prior Authorization program for Medicaid members, this FAX form must be signed by the ordering physician. However, if the ordering physician does not participate in UnitedHealthcare's Medicaid network and has not or is unwilling to obtain prior authorization, the rendering provider must obtain prior authorization and may use this FAX form to do so. In that case, this form must be signed by the rendering provider.

NOTE: In order to process your request completely and timely, please submit any pertinent clinical data (i.e. progress notes, treatment rendered, tests performed, labs results, radiology reports) to support your request. FAILURE TO PROVIDE SUFFICIENT CLINICAL INFORMATION WILL RESULT IN A DELAY IN RESPONDING TO YOUR REQUEST.

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Office information (Ordering provider):

Date: _____

Office Contact: _____ Phone #: _____ Fax #:_____

Requesting Provider: _____ Phone #: _____

Federal Tax ID #: _____ Request Type: Urgent _____ Routine _____

Urgent is defined as "significant impact to health of the member if not completed within 72 hours". For Expedited or Urgent cases, the preferred method of contact is by phone. Please call 1-866-889-8054

Which office are you representing? Ordering _____ Rendering _____

If you are the rendering provider, is the ordering provider contracted to participate in the:
UnitedHealthcare Medicare Advantage network? Yes _____ No _____
UnitedHealthcare Medicaid network? Yes _____ No _____

Member Information:

Member Name: _____ Date of Birth: _____
First Last

Member ID#: _____ Member Group #: _____

Rendering Provider Information (ONLY required for Prior Authorization requests for Medicare and Medicaid members):

Rendering Provider: _____

Federal Tax ID #:_____ Phone #: _____ Fax #: _____

Address:_____
Street City State Zip Code

Clinical Information:

CPT/HCPCS Code: _____ ICD-9 Code: _____

Symptoms and complaints	Duration

Office visit and physical exam findings:

Physical Exam Findings	Date	Results

NOTE: In order to process your request completely and timely, please submit any pertinent clinical data (i.e. progress notes, treatment rendered, tests performed, labs results, radiology reports) to support your request. FAILURE TO PROVIDE SUFFICIENT CLINICAL INFORMATION WILL RESULT IN A DELAY IN RESPONDING TO YOUR REQUEST.

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Results of pertinent recent lab tests relevant to the current problem:

Test	Date	Results

Medications used for the current problem:

Medication	Duration and Dates	Effective Yes/No

Prior Tests (including x-ray, US, CT, MRI); treatments (surgery or physical therapy etc); biopsy results related to the current problem:

Test, intervention or surgery	Date	Results/ Effective Yes/No

Is there any other history or clinical facts supporting this requested examination? Use additional sheets if necessary (please include Member ID# at top of any additional sheets): _____

_____

_____

_____

Provider Signature _____ Date _____

Use additional sheets if necessary.

Please fax this form, along with any additional documentation, to UnitedHealthcare at **1-866-889-8061**.

For any questions, please call **1-866-889-8054**.

NOTE: In order to process your request completely and timely, please submit any pertinent clinical data (i.e. progress notes, treatment rendered, tests performed, labs results, radiology reports) to support your request. FAILURE TO PROVIDE SUFFICIENT CLINICAL INFORMATION WILL RESULT IN A DELAY IN RESPONDING TO YOUR REQUEST.