



Authorization Number: \_\_\_\_\_  
 (Valid for 90 days from date of request)

# Prior Authorization Request

FAX TO: 352-515-5975

STANDARD       EXPEDITED      
 Select EXPEDITED ONLY if the Member's life, health, or ability to regain maximum function is jeopardized. Do not use this form for authorizations that need immediate response (Urgent). Please call (352) 835-7151.

### Member Information

Member ID: \_\_\_\_\_ Request Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Member Last Name: \_\_\_\_\_ Member First Name: \_\_\_\_\_  
 Member Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### Requesting Provider

Tax ID# or NPI#: \_\_\_\_\_ Type: \_\_\_PCP \_\_\_Specialist\*  
 Provider Last Name: \_\_\_\_\_ Provider First Name: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Fax Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ \*Has PCP approved this request? \_\_\_Yes \_\_\_No \_\_\_I'm the PCP  
 (Failure to answer this question will delay the request. The response to this question is subject to audit of the PCP medical record for acknowledgement and approval, in accordance with your Ultimate Health Plans Provider Manual)

### Referred To and Servicing Providers

**Practitioner Name:** \_\_\_\_\_ **Tax ID# or NPI#:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **Contact Name:** \_\_\_\_\_  
**Phone Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Fax Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Facility Name:** \_\_\_\_\_ **Tax ID# or NPI#:** \_\_\_\_\_  
**Facility Type:** \_\_\_\_\_ **Contact Name:** \_\_\_\_\_  
**Phone Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Fax Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### Service Requested and Place of Service (POS)

<input type="checkbox"/> In-Office/Diagnostic Center POS 11	<input type="checkbox"/> Out-of-Network - All	<input type="checkbox"/> Physical Therapy POS 12	<input type="checkbox"/> Physical Therapy POS 62
<input type="checkbox"/> Dialysis POS 65	<input type="checkbox"/> Outpatient Hospital POS 22	<input type="checkbox"/> Occupational Therapy POS 12	<input type="checkbox"/> Occupational Therapy POS 62
<input type="checkbox"/> DME POS 12	<input type="checkbox"/> Inpatient Hospital POS 21	<input type="checkbox"/> Speech Therapy POS 12	<input type="checkbox"/> Speech Therapy POS 62
<input type="checkbox"/> Home Health POS 12	<input type="checkbox"/> Ambulatory Surgery Center POS 24		
<input type="checkbox"/> Transition of Care - All			

Planned Date of Service: From: \_\_\_\_\_ To: \_\_\_\_\_ Appointment Date: \_\_\_\_\_  
 Primary ICD-10 Code: \_\_\_\_\_ Description: \_\_\_\_\_

CPT-4 / HCPCS Code	Description of Procedure or Services	Visits / Frequency

Comments: \_\_\_\_\_

**This form may be returned unprocessed if not completely filled out with all requested information.** Authorizations will be given for medically necessary services only. This request cannot be processed without supporting documentation such as office visit notes, pertinent laboratory data, prior treatment note(s), etc. Payment is subject to verification of member eligibility, benefit coverage, and appropriate coding guidelines. Emergencies do not require prior authorization.

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