ULTIMATE HEALTH PLANS
Good health is where you live.

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)

☐ **In-Office/Diagnostic Center POS 11**
☐ **Dialysis POS 65**
☐ **DME POS 12**
☐ **Home Health POS 12**
☐ **Transition of Care - All**
☐ **Out-of-Network - All**
☐ **Outpatient Hospital POS 22**
☐ **Inpatient Hospital POS 21**
☐ **Ambulatory Surgery Center POS 24**

Therapy Services-In-Home
☐ **Physical Therapy POS 12**
☐ **Occupational Therapy POS 12**
☐ **Speech Therapy POS 12**

Therapy Services - Outpatient
☐ **Physical Therapy POS 62**
☐ **Occupational Therapy POS 62**
☐ **Speech Therapy POS 62**

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.