UNM HEALTH
Insurance Plan

# PRIOR AUTHORIZATION REQUEST FORM

**Request Date:** _____

**Future Admission / Surgery / Procedure Date:** _____

**Start of Care Date / Dates of Service:** _____

**Provider:** _____ **Office Rep:** _____

**PARTICIPATING PROVIDERS WITH ACCESS TO UNM HIP PROVIDER PORTAL (PLANLINK) ARE REQUIRED TO SUBMIT PRIOR AUTH REQUESTS THROUGH THE PORTAL ALONG WITHTHE APPROPRIATE CLINICAL INFORMATION.**

**AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT**

| | |
|---|---|
| **UNM HIP PRIOR AUTH**<br>**FAX NUMBER: 1-954-417-7105** | **UNM HIP PHONE #:**<br>**1-866-602-1751** |
| **MEMBER NAME:** | **MEMBER ID NUMBER:**<br>**D.O.B.:** |
| **REFERRED BY PROVIDER NAME:**<br>**PHONE NUMBER:**<br>**FAX NUMBER:**<br>**TAX ID NUMBER:** | **REFERRED TO PROVIDER NAME:**<br>**PHONE NUMBER:**<br>**FAX NUMBER:**<br>**TAX ID NUMBER:** |

**PRODUCT LINE: UNM HIP**

| | |
|---|---|
| ☐ **Standard Priority**<br>(PROCESS WITHIN 10 BUSINESS DAYS) | ☐ **Urgent\Expedited Priority**<br>(PROCESS WITHIN 3 BUSINESS DAYS) |

**Reason for request:**
**(Attach pertinent medical records to assist in medical necessity review and timeliness of decision)**

Diagnosis & ICD-10 Procedure & CPT _____

Comment _____

Place of Service: ☐ 11 (Office) ☐ 21 (IP Hospital) ☐ 24 (Amb Surg Ctr) ☐ 12 (Home)
☐ 22 (OP Hospital) ☐ **Other (Please specify)** _____

**Faciility Name:** _____

**Provider's Printed Name:** _____

**Provider's Signature:** _____ **Date:** _____

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