

NEVADA UNIVERSAL PRIOR AUTHORIZATION AND REFERRAL FORM PHYSICIAN / PROVIDER CHECKLIST - INSTRUCTION SUMMARY

The checklist below corresponds to the prior authorization and referral form and proceeds from left to right, line-by-line, as per the form. Be sure all of the information listed below is filled in on the form. Additionally, any other pertinent information should be attached and submitted to the health plan / utilization management company for review:

Health Plan Name & Member health plan ID number;

Health Plan phone/fax number;

Primary Care Provider name, address, phone and fax number;

Date of Request;

Requesting Provider name;

Member name & Social Security number;

Requesting Provider's Address, phone number & fax #;

Member's address and phone number;

Requesting Provider's Tax ID number;

HIPAA Provider Identification number;

Member's date of birth;

Contact person (name, phone and fax numbers) w/requesting provider;

Employer Group's name and phone number;

Other Insurance (s) involved;

Requesting Provider's Signature or Stamped Signature;

Diagnosis (including ICD code);

Procedure / Treatment Request (including CPT code), number of treatments requested, inpatient or outpatient, service requested by patient;

Service provider address and phone number;

Place of service, include name of facility and address, Requested procedure date / Start treatment date;

Current clinical findings and management - all requests for procedures/treatment require clinical information (attachments - information to support the proposed diagnosis, treatment/procedure may include, but are not limited to, the following:

- o Current clinical findings (progress reports, etc.)
- o Results of laboratory testing
- o Imaging studies (x-rays, etc.)

Call the health plan / utilization management company with any questions prior to submission of the form / attached information.

Submit prior authorization / referral form when all of the above are completed - include necessary attachments.