New Mexico Uniform Prior Authorization Form					
To file electronically, attach form: www.UHCProvider.com/paan		To file via facsimile, fax to: 1-855-352-1206			
To contact the coverage review team for UnitedHealthcare, please call the toll-free number on your health plan ID card between the hours of 8am					
to 5pm MST. For after-hours review, please contact the toll-free number on your health plan ID card.					
[1] Priority and Frequency					
a. Standard: [ ] Services scheduled for this date:		] Provider certifies that applying the standard review by jeopardize the life or health of the enrollee.			
c. Frequency: Initial [ ] Extension [ ] Previous Authorization #:					
[2] Enrollee Information					
a. Enrollee name:	b. Enrollee date of birth:	c. Subscriber/Member ID #:			
d. Enrollee street address:					
e. City:	f . State:	g. Zip code:			
[3] Provider Information: Ordering Provider [ ] Renderi Please note: processing delays may occur if renderi provider may need to initiate prior authorization.		opriate documentation of medical necessity. Ordering			
a. Provider name: b. Provider	a. Provider name:  b. Provider type/specialty:				
d. NPI #:		e. DEA# if applicable:			
f. Clinic/facility name:		g. Clinic/pharmacy/facility street address:			
h. City, State, Zip code	i. Phone number and ext.:	j. Facsimile/Email:			
[4] Requested medical or behavioral health course	of treatment/procedure/device i	information (skip to Section 8 if drug requested)			
a. Service description:					
	atient [ ] Home [ ] Office [ ] Other	er*[ ]			
c. *Please specify if other:  [5] HCPCS/CPT/CDT/ICD-10 CODES					
	HCPCS/CPT/CDT Code	c. Medical Reason			
a. Editorios io codo	1101 00/01 1/02 1 0000	C. Modical readon			
[6] Frequency/Quantity/Repetition Request					
a. Does this service involve multiple treatments? Yes [   No [ ] If "No," skip to Section 7.					
b. Type of service:		c. Name of therapy / agency:			
d. Units/Volume/Visits requested:	e. Frequency/length of	of time needed:			
[7] Prescription Drug					
a. Diagnosis name and code:					
b. Patient Height (if required):   c. Patient Weight (if required):					
d. Route of administration					
*Explain if "Other:"					
e. Administered: Doctor's office [ ] Dialysis Center [ ] Home Health/Hospice [ ] By patient [ ]					

f. Medication Requested	g. Strength (include both loading and maintenance dosage)	h. Dosing Schedule (including length of therapy)	i. Quantity per month or Quantity Limits
j. Is the patient currently treated with t *If " Yes," when was the treatment with			
k. Anticipated medication start date (N	·		
I. General prior authorization request. E medications over alternatives:		uested medications, including an exp	lanation for selecting these
I. Rationale for drug formulary or step-tl	nerapy exception request:		
□ Alternate drug(s) contraindicated o (1) Drug(s) contraindicated or tried;	r previously tried, but with adverse of (2) adverse outcome for each; (3) if t		
□ Patient is stable on current drug(s), he adverse clinical outcome below.	igh risk of significant adverse clinical o	utcome with medication change. Spec	sify anticipated significant
□ Medical need for different dosage an	d/or higher dosage, Specify below: (1	) Dosage(s) tried; (2) explain medical r	reason.
□ Request for formulary exception, S effective as requested drug; (2) if the therapy on each drug and outcome	pecify below: (1) Formulary or preferer erapeutic failure, length of therapy or		
□ Other (explain below)			
Required explanation(s):			
m. List any other medications patient w	ill use in combination with requested n	nedication:	
n. List any known drug allergies:			
[8] Previous services/therapy (includ	ing drug, dose, duration, and reasor	for discontinuing each previous se	ervice/therapy)
a.		Date Discontinue	
b.		Date Discontinue	d:
С.		Date Discontinue	q.
<b>.</b>		Bate Bloodhanae	u.
[9] Attestation Thereby certify and attest that all inform	ation provided as part of this prior aut	horization request is true and accura	ate.
Requester Signature		Date	
	<del></del>		
DO NOT WRITE BELOW THIS LINE. FI	ELDS TO BE COMPLETED BY PLAN		
Authorization#	Contact name		
Contact's credentials/designation			