Prior Authorization Request — Self-Funded Services

IHSFS Medical Management Department: Phone: (716) 504-3254 - Fax: (716) 250-7170

- **Use this form only if the member ID card says "Independent Health Self-Funded Services". Otherwise, use the Prior Authorization Commercial Products Form.**
- **All fields on this form must be completed. Failure to Complete any field may result in our inability to process your request.** Please be advised that Independent Health Self-Funded Services must have the necessary information to process the request timely.
- **You must submit clinical documentation to support your request**, such as: copy of physician's order and/or Certificate of Medical Necessity as well as all relevant medical records i.e. evaluations, imaging studies, labs, etc.

MEMBER ID: _____ **SUFFIX** _____

Member Name (First & Last) _____

DOB: _____ **Home/Cell Phone:** (_____) _____-_____

SERVICE BEING REQUESTED All applicable fields MUST be filled in as indicated

☐ **Outpatient Surgery/Procedure**	☐ **2nd Opinion, MD/Office ONLY**	☐ **Outpatient Therapy**
☐ **Inpatient Surgery/Procedure**	☐ **DME/P&A: Cost** _____ **Rental** ☐ **or Purchase** ☐	☐ **Mental Health - Describe Level of Care:** _____
☐ **Substance Abuse** **List ASAM number:** _____	☐ **Other (please describe):** _____	
Date(s) of Service:	**Diagnosis Code(s):**	
CPT or HCPC, etc. Code(s) if applicable, # of Units & Description: _____ _____ _____ _____		

REQUESTING PROVIDER INFORMATION All fields MUST be filled in

Name: _____ **NPI:** _____

Office Contact Name: _____ **TAX ID**: _____

Address: _____ **City**: _____ **State**: _____ **ZIP Code**: _____

Phone Number: (_____) _____-_____ **Ext:** _____ **Fax:** (_____) _____-_____

SERVICING PROVIDER INFORMATION All fields MUST be filled in- if same as Requesting, just state 'Same as Requesting' under name

Name: _____ **NPI**: _____

Office Contact Name: _____ **TAX ID:** _____

Address: _____ **City**: _____ **State:** _____ **ZIP Code**: _____

Phone Number: (_____) _____-_____ **Ext:** _____ **Fax:** (_____) _____-_____

SERVICING FACILITY INFORMATION All fields MUST be filled in

Name: _____ **NPI:** _____

Office Contact Name: _____ **TAX ID**: _____

Address: _____ **City:** _____ **State**: _____ **ZIP Code**: _____

Phone Number: (_____) _____-_____ **Ext:** _____ **Fax**: (_____) _____-_____

For all urgent requests, the request must demonstrate that failure to render a decision within 72 hours could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, or in the opinion of the ordering physician, that a delay would subject the claimant to severe pain that cannot be adequately managed.

If you believe this to be an urgent request, please provide supporting documentation to justify your request and check the following box and provide a rationale: ☐ **Urgent Request Rationale:** _____

If you are an out-of-network provider requesting an in-network benefit, please provide supporting documentation and check the following: ☐ **Out-of-Network Provider Requesting In-Network Benefit**

UnitedHealthcare® Options PPO Network

Independent Health SELF-FUNDED SERVICES