

TEC Delegation Plans Prior Authorization Request Form

For use with the following insurances ONLY:

- **United Health Care Medicare Advantage HMO TEC PCP Insurance ID #** _____
- **Premera Medicare Advantage HMO TEC PCP Insurance ID #** _____
- **Humana Medicare Advantage HMO TEC PCP Insurance ID #** _____

DO NOT USE THIS FORM TO REQUEST: Skilled Nursing Facility Admission/ INPT Rehab Admission/ Long Term Acute Hospital Admission. Please Call 425-317-3494 and ask for the UM RN.

****CLINICAL DOCUMENTATION MUST BE INCLUDED WITH REQUEST****

Date: _____ **Contact Person:** _____ **Clinic/Business Name:** _____

Phone Number: _____ **Fax Number:** _____

To process your prior authorization, we will need the following:

Patients Name: _____ **DOB:** _____

Requesting Provider: _____

Tax ID: _____ **NPI:** _____

Address: _____

Servicing Facility: _____

Tax ID: _____ **NPI:** _____

Address: _____

CPT/HCPC Codes & Quantity: _____

Durable Medical Equipment Price: _____

For Durable Medical Equipment, please include individual price per item and total price for request

ICD10 Codes: _____

Dates of Service: _____

Level of Service *(circle one)*: Inpatient or Outpatient **Number of Inpatient Days:** _____

Can clinical data be found at Care Everywhere? **Yes No**

If yes, it is **not** necessary to fax clinical data as we have access to Care Everywhere.

Confidentiality Notice: The documents in this correspondence may contain confidential health information that is privileged and subject to state and federal privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA). This information is intended for the sole use of the addressee named above. If you are not the intended recipient, you are hereby notified that reading, disseminating, disclosing, distributing, copying, acting upon, or otherwise using the information contained in this correspondence is strictly prohibited.

****Request is invalid if any of the above information is missing****