NEVADA UNIVERSAL
PRIOR AUTHORIZATION AND REFERRAL FORM

HEALTH PLAN NAME & MEMBER HEALTH PLAN I.D. #: **Health Plan Phone/Fax #:**	Primary Care Provider Name / Address / Phone & Fax #:
Date of Request:	Requesting Provider Name:
Member Name & SS#:	Requesting Provider's Address & Phone #: **Requesting Provider's Fax #:**
Member's Address & Phone #:	Requesting Provider's Tax ID #: HIPAA Provider Identification #:
Member DOB:	Contact Person (Name, Phone & Fax #):
Employer Group's Name & Phone #: Other Insurance (s):	Requesting Provider's Signature or Stamped Signature:
Diagnosis (inc. ICD code):	Procedure / Treatment Request (inc. CPT code): Number of Treatments Requested: _____ Inpatient / Outpatient Service Requested by Patient *Yes No*
Service Provider / Address / Phone #:	Place of Service / Facility and Address: Requested Procedure Date / Start Treatment Date:

Current Clinical Findings and Management
All procedures/treatment requested require clinical information (may use this space - also see requirements below and attach to this form):

***Pertinent Attachments** = Information to support the proposed diagnosis, treatment / procedure; i.e. current clinical findings (progress reports), results of laboratory testing, imaging studies (x-rays, etc.) must be submitted to prevent processing delays.*

Area for internal health plan use only	*Authorization:*		*Date of Authorization:*	*Pended / Denied: (Reason):*
Health plan contact name & phone #:	*Yes*	*No*	*Authorization Number:*	

All sections of this form must be completed.

****On adverse determinations a reconsideration / expedited appeal may be requested.***

This referral/authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, and other terms & conditions set forth in the member's Evidence of Coverage, Certificate of Coverage, or Self Insured Employer's Plan Documents.

The information contained in this form, including attachments, is privileged & confidential & is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.

Revised 12/11/00