UniCare Health Plan of West Virginia, Inc.
Medicaid Managed Care

Prior Authorization Request Form

UniCare Health Plan of West Virginia, Inc. (UniCare) precertification phone number: **1-866-655-7423** Fax: **1-855-402-6983**
To prevent a delay in processing your request, please fill out the form in its entirety with all applicable information.

Today's date: **Provider return fax:**

Member information

First name: Last name: UniCare member ID:

Address: City, state and ZIP code:

Date of birth: Contact phone:

Does member have additional health insurance? ☐ Yes ☐ No
If yes, please provide additional information:

Referring provider ☐ Contracted ☐ Noncontracted (complete the below box if individual provider is NOT billing)

Full name: Specialty:

NPI: TIN:

Office contact name: Office phone: Office fax:

Address: City, state and ZIP code:

Servicing provider ☐ Contracted ☐ Noncontracted (complete the below box if individual provider is billing)

Full name: Specialty:

NPI: TIN:

Office contact name: Office phone: Office fax:

Address: City, state and ZIP code:

Servicing facility ☐ Contracted ☐ Noncontracted (complete the below box if the facility is billing)

Facility name:

NPI: TIN:

Facility contact name: Facility phone: Facility fax:

Address: City, state and ZIP code:

Requested service (for type of service, check all that apply)

☐ **Emergent**: Use for all non-elective **inpatient** admissions only when the member has already been admitted.
☐ **Urgent**: Use when provider indicates that the service is urgent, emergent or expedited or when the service is required to avoid a delay in discharge from an inpatient admission.
☐ **Elective**: Use for routine services.

ICD-10-CM code(s): **Date/date range of service:**

CPT code(s) (include requested units):

Place of service: ☐ Acute IP rehab facility ☐ Ambulatory surgery center ☐ Home ☐ Hospital ☐ Independent clinic/OP therapy ☐ Independent lab ☐ Office ☐ Other:

Type of service: ☐ Diagnostic imaging ☐ Diagnostic lab ☐ Diagnostic study ☐ Durable medical equipment ☐ Emergent inpatient ☐ Home health ☐ Office visit ☐ Planned inpatient ☐ PT/OT/ST ☐ Radiation therapy ☐ Surgery ☐ Other:

Additional information:

☐ **Episode of care** ☐ **Court ordered** ☐ **Member is currently inpatient**

Please submit all appropriate clinical information, provider contact information and any other required documents with this form to support your request. If this is a request for extension or modification of an existing authorization from UniCare, please provide the authorization number with your submission.

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