Reset Form

Prior Authorization for Out-of-Network Mental Health & Substance Use Disorder Services

FYI ***Incomplete, illegible or inaccurate forms will be returned to sender.*** Please complete the entire form and allow 14 calendar days for decision. **Submission of all relevant clinical information with the request will reduce the number of days for the decision.**

For questions, call Mental Health and Substance Use Disorder Services at:
612-676-6533 or **1-833-276-1185**

To **fax** form and any relevant documentation:

For **initial** admission notifications:
612-884-2033 or **1-855-260-9710**

Submit Request: UCare's Secure Email Site
Intake: MHSUDservices@ucare.org

MEMBER INFORMATION

UCare ID _____ PMI _____

Member Name _____ DOB _____

Address _____

City, State, Zip _____ Phone _____

SERVICING PRACTITIONER INFORMATION

Practitioner Name _____ NPI Number _____

Service Location Address _____

City, State, Zip _____

Contact Phone _____ Fax _____

REQUESTER INFORMATION

Request Sent By _____ Email _____

Phone _____ Total Pages Faxed _____

◉ STANDARD REVIEW	○ EXPEDITED REQUEST
Standard review timeframe for an authorization decision is within 14 calendar days or 10 business days from the date the request was received, as expeditiously as the member's health condition requires.	Only request an urgent/ emergent review if waiting the standard review timeframe would potentially jeopardize the member's health, life, or ability to regain function. Expedited decision within 72 hours. Billing and retrospective authorizations are not expedited.

Review our provider manual criteria references. Submit documentation to support medical necessity along with this request. ***Failure to provide required documentation may result in denial of request*****.**

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REASON FOR OUT-OF-NETWORK AUTHORIZATION REQUEST

☐ **Referred from another provider**

Referring physician name _____

Clinic/Facility _____ Contact Phone Number _____

☐ **Access Issues**

☐ **Member Preference**

☐ **Network / Benefit Exception**

☐ **Previous Insurance Approval** *(attach previous authorization as necessary)*

SERVICE REQUEST/ DATES/ PROCEDURE CODES/ UNITS

Please list all necessary code(s) and units associated with your visit.

Service Requested: _____

ICD-10: _____ Date of Service _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

DOCUMENTS FOR REVIEW

☐ Comprehensive Assessment

☐ Diagnostic Assessment

☐ Discharge Summary

☐ Functional Assessment

☐ Individual Treatment Plan (current)

☐ Level of Care Assessment (per DHS guidelines)

☐ Medication Administration Record

☐ Progress Notes (from the past 30 days, if available)

☐ Other documents _____

Additional Information that may support medical necessity: