HealthPartners®

Prior Authorization Request for In-Network Benefits - UnityPoint Employer Group

Note: HealthPartners will only approve in-network benefit requests if we can confirm that medically necessary covered care for the condition is not available in the member's network. Form must be submitted and request approved prior to obtaining services. Sign in at healthpartners.com/provider and use the Authorizations and referrals link to check the status of your prior authorization request.

Member information

First Name _____ MI ____ Last Name _____

HealthPartners ID # _____ DOB _____

Requester information

Form completed by: First Name _____ Last Name _____

Your business name _____

Your business street address _____

Your business city _____ Your business state _____ Your business zip _____

Phone* _____ Fax** _____

Ordering physician information

Physician first name _____ Physician last name _____

Specialty _____ NPI _____

Clinic name _____

Clinic street address _____

Clinic city _____ Clinic state _____ Clinic zip _____

Clinic tax ID (claim may be rejected if incorrect) _____

Email _____ Phone* _____ Fax** _____

Out of Network Clinician Information

Physician first name _____ Physician last name _____

Specialty _____ NPI _____

Clinic name _____

Clinic street address _____

Clinic City _____ Clinic state _____ Clinic zip _____

Clinic tax ID (claim may be rejected if incorrect) _____

Email _____ Phone* _____ Fax** _____

Out of Network Facility Site

Facility name _____

Facility street address _____

Facility City _____ Facility state _____ Facility zip _____

Billing tax ID (claim may be rejected if incorrect) _____

Phone* _____ Fax** _____

**Confidential voicemail required*

***For outcome notification*

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Service Information

Primary diagnosis code _____ Description _____

Secondary diagnosis code _____ Description _____

Procedure codes (s) _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

Service description _____

_____

Proposed date of service _____ How many units/visits requested: _____

Will waiting the standard review time seriously jeopardize member's health, life or ability to regain maximum functioning? ☐ yes ☐ no

Clinical reason for urgency (not scheduling issues) _____

Fax completed forms to **(952)853-8713**. Call Utilization Management (UM) at **(952)883-6333** with questions. Incomplete forms will be returned. Submit clinical documentation to support your request.

Is care for the requested specialty available within the UnityPoint Health or ACO specialty network?

- ☐ Yes - Refer patient to UnityPoint Health or ACO Specialty provider
- ☐ No - Can care be provided by the University of Iowa? University of Iowa is the preferred out of network provider per the UnityPoint ACO contracted provider agreement.
  - ☐ Yes - Complete this form to refer patient to the University of Iowa
  - ☐ No - Provide rationale and complete this form

Is this request based on the preference and/or convenience of the member, without clinical justification to support this request? ☐ Yes ☐ No

Summary of UnityPoint Health or ACO specialty providers the patient has seen for this diagnosis:

Provider: _____ Specialty: _____
Dates: _____

Treatments: _____

Outcomes: _____

Provider: _____ Specialty: _____
Dates: _____

Treatments: _____

Outcomes: _____

Has the patient seen this out of network provider in the past? ☐ Yes ☐ No
Date of last visit: _____ Please attach clinic visit notes for past visits

Level of Care: ☐ Office Consult Only ☐ Consult & Diagnose ☐ Consult, Diagnose, & Treat ☐ Multiple Specialties ☐ Inpatient

Provide a clinical explanation of why the request service(s) can only be provided by this out of network provider: (Note: HealthPartners will only approve in-network benefit requests if we can confirm that medically necessary covered care for the condition is not available in the member's network.) _____

_____