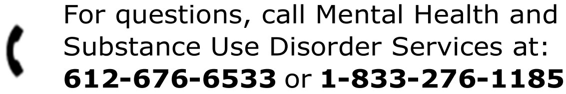
Mental Health & Substance Use Disorder Out-of-Network Prior Authorization Form

FYI ***Incomplete, illegible or inaccurate forms will be returned to sender.*** Please complete the entire form and submit documentation to support medical necessity along with this request. Failure to provide required documentation may result in denial of request. Review our provider manual criteria references.



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

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 ______________________

ICD-10: ______________________ Phone ______________________

SERVICING FACILITY/PRACTITIONER INFORMATION

Facility ______________________ NPI Number ______________________

Practitioner ______________________ NPI Number ______________________

Service Location Address ______________________

City, State, Zip ______________________

Contact Phone ______________________ Fax ______________________

REQUESTER INFORMATION

Request Sent By ______________________ Phone ______________________

Fax (if different than above) ______________________ Total Pages Faxed ______________________

Email ______________________

MH&SUD Out-of-Network (Continued)

PLEASE SELECT STANDARD OR EXPEDITED REQUEST BELOW

STANDARD REQUEST

- Medicare and Medicaid decision within 10 business days.
- IFP decision within 5 business days.

EXPEDITED REQUEST

- Only request an urgent/emergent review if waiting for the standard review timeframe would potentially jeopardize the member's health, life, or ability to regain function.
- Medicare and Medicaid decision within 72 hours.
- IFP decision within 48 hours, including 1 business day.
- Billing and retrospective authorizations are not expedited.

1. Proposed date of service: ______________________________
   - Billing and retrospective authorizations are not expedited.
2. Clinical reason for urgency (**unrelated to scheduling issues**):
3. Provide a contact name and number available for this request:
   - Due to the expedited processing time, please ensure that the designated contact is readily accessible should further information be required.

REASON FOR OUT-OF-NETWORK AUTHORIZATION REQUEST

☐ **Referred from another practitioner**

Referring practitioner name ______________________________

Clinic/Facility ______________________________ Contact Phone Number ______________________________

☐ **Access Issues**

☐ **Benefit Exception**

☐ **Member Preference**

☐ **Network Exception** (a request to allow a member to receive services from an out-of-network provider)

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

SERVICE REQUEST/DATES/PROCEDURE CODES/UNITS

DATES REQUESTED	Start Date	End Date

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

Service Requested: ______________________________

Procedure Code ______________________________ Units Requested ______________________________

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Procedure Code ______________________________ Units Requested ______________________________

MH&SUD Out-of-Network (Continued)

ADDITIONAL INFORMATION

Please include any additional information that may support medical necessity/rationale for out-of-network request: