PRE-DETERMINATION REQUEST FORM (MEDICARE ONLY)

FYI: 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 the request.

Fax form and relevant clinical documentation to:
612-884-2499 or 1-866-610-7215

For questions, call:
612-676-3300 or 1-888-531-1493

E-Mail: HCM_Fax@ucare.org

UCare's Secure E-mail Site

PATIENT INFORMATION:		
Name:		
Member ID:	PMI:	
Address:		
City:	State:	Zip Code:
Date of Birth:	Phone:	
Member Product (required)*:		

ORDERING PRACTITIONER INFORMATION:		
Ordering Practitioner Name:	ID/ NPI Number:	
Ordering Practitioner Address:		
City:	State:	Zip Code:
Phone:	Fax:	

SERVICING CLINIC INFORMATION:		
Servicing Practitioner Name:		
Servicing Practitioner Clinic Location Name (required)*:		
Clinic Location NPI Number (required)*:		
Clinic Location Address:		
City:	State:	Zip Code:

CONTACT PERSON FOR PRIOR AUTHORIZATION QUESTIONS:	
Name:	
Phone:	Fax:
Email:	

REASON FOR PRE-DETERMINATION REQUEST: (SELECT ONE)

- ☐ Service/ Procedure does not meet Original Medicare Necessity Criteria
- ☐ Service/ Procedure is not covered by Original Medicare
- ☐ Investigative or experimental procedure:
- ☐ Other:

PROCEDURE CODE(S) CPT/ HCPCS:			
Description of Request:			

SERVICE/ ITEM REQUESTED:			
Number of Units/ Visits Requested:			
Frequency (if applicable):			
Start Date Requested (required):			
End Date Requested:			
Place of Residence:	☐ Skilled Nursing Facility (SNF)	☐ Assisted Living Facility (ALF)	☐ House
	☐ Apartment	☐ Group Home	

ICD-10 DIAGNOSIS CODE(S):			
Diagnosis description (include all) relevant to this request:			

☐ STANDARD REQUEST	☐ EXPEDITED REQUEST
➢ Medicare and Medicaid decision within 10 business days. ➢ IFP decision within 5 business days.	➢ 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. ➢ 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:	
2. Will waiting the standard review time seriously jeopardize member's health, life or ability to regain maximum function? ☐ Yes ☐ No	
3. Clinical reason for urgency (unrelated to scheduling issues):	
Physician Signature:	

CONFIRM AND COMPLETE THE REQUIRED STEPS TO PROCEED:	
☐	Clinical notes supporting any of the above have been included in the submission form. (Incomplete submission can delay decision time)

Notes: Do not use this form for Injectable Drug Authorization Request, DME Authorization, Home Care Services, or Mental Health and Substance Use Disorder Services.

Please refer back to **UCare.org** for appropriate forms.