OPTUM®

Prior Authorization Fax Form
Fax completed form to: **1-877-251-0387**

Today's Date:			
Member Information			
Member Last Name	Member First Name	Member ID	Date of Birth
Provider Information ☐ In-Network ☐ Out-of-Network			
Requesting Provider		Provider Tax ID/National Provider ID (NPI)	
Requesting Provider Address		Requesting Provider Telephone/Fax Number	
Contact Name		Contact Telephone /Fax Number	
Servicing Provider/Facility ☐ In-Network ☐ Out-of-Network			
Name of Servicing Provider		Servicing Provider Tax ID/NPI	
Servicing Provider Address		Servicing Provider Telephone/Fax Number	
Name of Servicing Facility		Servicing Facility Tax ID/NPI	
Servicing Facility Address		Servicing Facility Telephone/Fax Number	
Service Request			
☐ Routine ☐ Expedited		☐ Inpatient ☐ Outpatient	
Anticipated Date of Service:			
Diagnosis Code(s):		CPT/HCPS code(s):	
Description of Service:			
Number of visits/units/days:	Start Date:	End Date:	Frequency:

Please fill in all applicable data and submit all relevant clinical information for this request.