



**NEVADA UNIVERSAL
PRIOR AUTHORIZATION AND REFERRAL FORM**

HEALTH PLAN NAME & MEMBER HEALTH PLAN I.D. #:  	Primary Care Provider Name / Address / Phone & Fax #:
Health Plan Phone #: 775-982-3700 Fax #: 775-982-3744	
Date of Request:	Requesting Provider Name:
Member Name & SS #:	Requesting Provider's Address & Phone #:
Member's Address & Phone #:	Requesting Provider's Fax #:
Member DOB:	Requesting Provider's Tax ID #:
Employer Group's Name & Phone #:	HIPAA Provider Identification #:
Other Insurance (s):	Contact Person (Name, Phone & Fax #):
Diagnosis (inc. ICD code):	Requesting Provider's Signature or Stamped Signature:
Procedure / Treatment Request (inc. CPT code):	Number of Treatments Requested: _____ Inpatient / Outpatient Service Requested by Patient Yes No
Service Provider / Address / Phone #:	Place of Service / Facility and Address:
Requested Procedure Date / Start Treatment Date:	
Current Clinical Findings and Management All procedures/treatment requested require clinical information (may use this space - also see requirements below and attach to this form):	
<i>Pertinent Attachments = Any information to support the proposed diagnosis, treatment / procedure, such as current clinical findings (progress reports), results of laboratory testing, imaging studies (x-rays, etc.) must be submitted to prevent processing delays.</i>	

Area for internal health plan use only	Authorization:	Date of Authorization:	Pended / Denied: (Reason):
Health plan contact name & phone #:	Yes No	Authorization Number:	

****All sections of this form must be completed.***

*****On adverse determinations a reconsideration / expedited appeal may be requested.***

This referral/authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, and other terms and conditions set forth in the Member's Evidence of Coverage, Certificate of Coverage, or Self Insured Employer's Plan Documents.

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