



**NEVADA UNIVERSAL  
PRIOR AUTHORIZATION AND REFERRAL FORM**

<b>HEALTH PLAN NAME &amp; MEMBER HEALTH PLAN I.D. #:</b>   	Primary Care Provider Name / Address / Phone & Fax #:
<b>Health Plan Phone #: 775-982-3723 Fax #: 775-982-3744</b>	
<b>Date of Request:</b>	Requesting Provider Name:
<b>Member Name &amp; SS #:</b>	Requesting Provider's Address & Phone #:
<b>Member's Address &amp; Phone #:</b>	Requesting Provider's Fax #:
<b>Member DOB:</b>	Requesting Provider's Tax ID #:
<b>Employer Group's Name &amp; Phone #:</b>	HIPAA Provider Identification #:
<b>Other Insurance (s):</b>	Contact Person (Name, Phone & Fax #):
<b>Diagnosis (inc. ICD code):</b>	Requesting Provider's Signature or Stamped Signature:
Procedure / Treatment Request (inc. CPT code):	Number of Treatments Requested: _____
Inpatient <input type="checkbox"/> / Outpatient <input type="checkbox"/>	Service Requested by Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Service Provider / Address / Phone #:</b>	Place of Service / Facility and Address:
Current Clinical Findings and Management <u>All</u> procedures/treatment requested require clinical information (may use this space - also see requirements below and attach to this form):	Requested Procedure Date / Start Treatment Date:
<p><b><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></b></p>	

<b>Area for internal health plan use only</b>	<b>Authorization:</b>	<b>Date of Authorization:</b>	<b>Pended / Denied: (Reason):</b>
<b>Health plan contact name &amp; phone #:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Authorization Number:</b>	

***\*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.*

*The information contained in this form, including attachments, is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.*