UM Department Phone #: 800-953-8854

Inpatient Admission Notification Fax #: 1-800-385-4169
Post Discharge Services UM Fax #: 1-855-905-5936
Scheduled Inpatient & Outpatient Services & Transplant Request Fax #: 1-800-953-8856

MARYLAND physicians care
MANAGED CARE ORGANIZATION

*Requestor's Contact Name: *Requestor's Contact #:

Patient Information:

*Name: *DOB:

*Patient ID #: *Patient Phone #:

*Service Is: ☐ Elective / Routine ☐ Expedited / Urgent

Note: Selected Expedited/ Urgent to prevent serious deterioration in health or jeopardize ability to regain maximum function

*Does the Member have other insurance? ☐ Yes ☐ No If Yes, other insurer

***Service Type Requested:** Please review plans benefit prior to request

Inpatient	Outpatient	Other
Fax to 1-800-385-4169	☐ Surgical Procedure	☐ Home Health
☐ Emergency Admission *(No CPT Code required)*	☐ Chiropractic Services	☐ Private Duty Nursing
☐ OB/Maternity	☐ Cardiac Rehab	☐ Home Infusion/ IVT
☐ NICU/Detained/Sick Baby	☐ Audiology Services/DME	☐ Hospice Care **CTI required*
☐ Transplant Admission	☐ Hyperbaric Oxygen Therapy	☐ Prosthetics/Orthotics
Fax to 1-855-905-5936	☐ Pulmonary Rehab	☐ Neuropsych Testing
☐ Skilled Nursing Facility/Acute Rehab	☐ Sleep Study	☐ Genetic Testing
☐ Hospice **CTI Required*	☐ Transgender Procedure	☐ Enteral Formula/TPN & Supplies
☐ Discharge Planning Services	☐ Transplant Evaluation	**Enteral/Nutritional Supplement Form Required*
Fax to 1-800-953-8856	☐ Voluntary Sterilization	☐ DME Purchase _____
☐ Transplant Listing	**Sterilization Consent Form Required*	☐ DME Rental _____
☐ Elective Admission	☐ Other _____	***Pharmacy Medication Requests***
☐ Surgical Procedure		*Submit on Medical Benefit RX Request Form*

Procedure Information:

***ICD 10 Diagnosis:** Diagnosis Description:

***CPT/HCPCS** Code *(Include Unit per CPT/HCPCS Code):*

***Date(s) of Service:** ***# of Units/Visits:**

Provider Information:

Requesting Provider Is this the patient's Primary Care Physician? ☐ Yes ☐ No

*Name: *NPI *TIN:

*Phone: *Fax

*Address:

Rendering Provider ☐ Same as the Requesting Provider

If Requesting and Rendering providers differ, complete section below

*Name: *NPI *TIN:

*Phone: *Fax

*Address:

Facility ☐ N/A

*Name: *NPI *TIN:

*Phone: *Fax

*Address:

Request for extension to existing authorization number:

PLEASE COMPLETE ALL SECTIONS WITH AN ASTERISK AND ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NECESSITY.
INCOMPLETE INFORMATION MAY DELAY THE PROCESS.
Always verify eligibility, benefits, and prior authorization requirements