MARYLAND physicians care
MANAGED CARE ORGANIZATION

UM Department Phone #: 800-953-8854

Inpatient Admission Notification Fax #: 1-800-385-4169

Scheduled Inpatient & Outpatient Services & Transplant Request Fax #: 1-800-953-8856

DISCHARGE PLANNING REQUESTS Fax #: 1-855-905-5936

*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 ☐ Emergency Admission (No CPT Code required) ☐ Surgical Procedures ☐ Elective Admission ☐ OB/Maternity ☐ NICU/Detained/Sick Baby ☐ Transplant **Fax to 1-833-424-8013** ☐ Skilled Nursing Facility ☐ Acute Rehab ☐ Hospice *CTI required ☐ Discharge Planning Services	☐ Surgical Procedure ☐ Chiropractic Services ☐ Cardiac Rehab * *Submit completed Cardiac Rehab Auth Form with request* ☐ Audiology Services/DME ☐ Hyperbaric Oxygen Therapy ☐ Pulmonary Rehab ☐ Sleep Study ☐ Transgender Procedure ☐ Transgender Evaluation ☐ Transplant Listing ☐ Bariatric Surgery ☐ Voluntary Sterilization **Sterilization Consent Form Required*	☐ Home Health ☐ Private Duty Nursing ☐ Home Infusion/ IVT ☐ Hospice Care *CTI required ☐ Prosthetics/Orthotics ☐ Neuropsych Testing ☐ Genetic Testing ☐ Enteral Formula/TPN & Supplies **Enteral/Nutritional Supplement Form Required* ☐ DME Purchase * _____ ☐ DME Rental * _____ ***Pharmacy Medication Requests*** *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