MARYLAND physicians care
MANAGED CARE ORGANIZATION

UM Department Phone #: 800-953-8854
Inpatient Admission Notification Fax #: 1-800-385-4169
Fax all IP/Concurrent Clinical to 1-855-905=5939
Post Discharge Services UM Fax #: 1-855-905-5936
Scheduled Inpatient & Outpatient Services & Transplant Request Fax #: 1-800-953-8856

*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

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time of services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.
Confidentiality: The information contained in the transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient and use, distribute, or coping is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.