

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/Fax #:			
Date of Request:	Requesting Provider Name:		
Member Name & SS#:	Requesting Provider's Address & Phone #:		
Member's Address & Phone #:	Requesting Provider's Fax #:		
	Requesting Provider's Tax ID #:		
Member DOB:	HIPAA Provider Identification #:		
Employer Group's Name & Phone #:	Contact Person (Name, Phone & Fax #):		
Other Insurance (s):	Requesting Provider's Signature or Stamped Signature:		
Diagnosis (inc. ICD code):	Procedure / Treatment Request (inc. CPT code):		
	Number of Treatments Requested: _____ Inpatient / Outpatient Service Requested by Patient Yes No		
Service Provider / Address / Phone #: Andrew H. Hwang, M.D. 653 N. Town Center Dr., Suite 407 Las Vegas, NV 89144 P: (702) 728-5686 F: (702) 628-9030	Place of Service / Facility and Address: Las Vegas Pediatric Urology. 653 N. Town Center Dr. Suite 407, Las Vegas, NV 89144 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):			
<p><i>Pertinent Attachments = Information to support the proposed diagnosis, treatment / procedure; i.e. current clinical findings (progress reports), results of laboratory testing, imaging studies (x-rays, etc.) must be submitted to prevent processing delays.</i></p>			

<i>Area for internal health plan use only</i>	Authorization:	Date of Authorization:	Pended / Denied: (Reason):
<i>Health plan contact name & phone #:</i>	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 & conditions set forth in the member's Evidence of Coverage, Certificate of Coverage, or Self Insured Employer's Plan Documents.

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