Home and Community Based Service (HCBS) Provider Request Form

Is this request/service required urgently? YES/NO

Once complete, please fax back to **844-897-4552** or Email: **uhc_mn_ltss_cc@uhc.com**

Today's Date: **Member Information**	
First name	Last Name
Member PMI	DOB
Member Product (circle one) : SNBC MSC+ MSHO	Elderly Waiver (circle one): YES NO
PCP First/Last Name:	PCP Clinic:
Additional Member Information:	

****Note**** Please complete the form with the required information below. Please submit supporting clinical documentation/medical records/provider orders to support the request for these services.

Service Authorization

Servicing Provider	**Participating**	**Non-participating**
Name of Provider/Facility:		
NPI/UMPI:	Tax ID:	
Address: City/State: Zip:	Phone: Fax:	
Contact Name:	Contact Phone:	
Requested Service		
ICD-10/Diagnosis Code(s):	CPT/HCPCS Code(s) & Units: (Please include modifiers if applicable) Code Description(s): Price: (If applicable)	
Date/Date Range of Service	Start Date:	End Date:
Frequency Requested: (# of units/visits per day, week, month, etc.)		

Disclaimer: Authorization is subject to member eligibility and benefit coverage. Approval of authorization is not a guarantee of payment.