UnitedHealthcare Community Plan
Outpatient Services
(877) 840-5581 Fax

BEHAVIORAL HEALTH AUTHORIZATION REQUEST FORM - HAWAII

Today's Date: _____ URGENT: ☐ Yes ☐ No

MEMBER INFORMATION

Member Name: _____ DOB: _____

Home Address: _____ Gender: _____

City, State, and ZIP Code: _____ Phone: _____

INSURANCE INFORMATION

QUEST Integration Plan: _____ QUEST ID #: _____

Medicare Plan: _____ Medicare ID #: _____

Other Insurance: _____ Other Plan ID #: _____

SERVICING PROVIDER INFORMATION

Facility Name: _____ Service Setting: _____

Clinician Name: _____ Phone: _____

Provider Address: _____ Fax: _____

Office Contact Name: _____ Tax ID #: _____

CLINICAL

For requests for continuation of services, send initial and / or updated evaluation and progress notes along with servicing provider's signature. For psychological testing requests, please indicate which tests you plan to administer. For methadone maintenance requests, please include U/A results.

Date(s) of Service, From: _____ To: _____

ICD-10-CM CODE(S)	DIAGNOSES	
CPT / HCPC CODE(S)	**PROCEDURE(S) / TREATMENT(S)**	**# OF VISIT(S) or UNIT(S)**