



Preauthorization for Medical Necessity

Use this form to request pre-authorization for:

- Gastric Bypass
- Gamma Knife Scans
- Reconstructive/Cosmetic Procedures
- Out-of-Area/Out-of-Network Care
- Contractual Exclusions
- Experimental/Investigational Procedures
- Selected Medications
- Selected Other Procedures and Treatments (e.g., for TMJ, Genetic Counseling, other)

Date:	Expedite? <input type="checkbox"/> Yes <input type="checkbox"/> No	Reference No:	For Univera Use Only
Name of Ordering/Requesting Physician:			
Patient / Member Information			
Member Name :		Member ID No.	
Member DOB:		Plan (select one): <input type="checkbox"/> Univera <input type="checkbox"/> Medicare PPO <input type="checkbox"/> SeniorChoice	
Member Home Phone Number:		Referral Number:	
Diagnosis/Procedure Information			
<i>Diagnosis Description</i>	<i>ICD-9 Code</i>	<i>Procedure Description</i>	CPT Code*
Information about Referral Specialist or Out-of-Network Physician*			
Physician Name:		Physician Tax ID Number:	
Physician Address:		Physician Phone Number:	
Physician Univera ID Provider Number:		Physician Fax Number:	
Facility Information (if applicable)			
Facility Name:		Facility Phone Number:	Ext.
Facility Address:		Date of Procedure:	
To Submit This Request			
<ul style="list-style-type: none"> ▪ Complete this form in full. ▪ Attach a Letter of Medical Necessity and copies of clinical notes, diagnostic test results, pathology reports, and other pertinent clinical information. This information must accompany the request. ▪ Fax or mail to: Univera Healthcare, Benefits Interpretation, 205 Park Club Lane, Buffalo, NY, 14221, (716) 857-6361 or 1 (800) 404-1442 			

***REQUIRED**

Authorization does not guarantee or confirm that benefits will be paid.

Payment of claims is subject to member eligibility and to contract limitations, provisions, and exclusions.