NEVADA UNIVERSAL
PRIOR AUTHORIZATION FORM

Health Plan of Nevada (HPN): ☐ **Nevada Exchange:** ☐ **HPN POS:** ☐ **Tier I (HMO)** ☐ **Tier II (PPO)** ☐ **Tier III** **Health Plan of Nevada Medicaid:** ☐ **Sierra Health and Life:** ☐ **Out of plan** ☐ **Sierra Health and Life EPO** ☐	Primary Care Provider Name / Address / Phone & Fax #:
Phone: (LV) 702-243-8499 (outside LV) 888-224-4036 **Fax #: (LV) 702-304-7411 (outside LV) 800-282-8845**	Requesting Provider Name:
Date of Request:	
Member Name & member number:	Requesting Provider's Address & Phone #: **Requesting Provider's Fax #:**
Members Address & Phone #:	Requesting Provider's Tax ID #: HIPAA Provider Identification #:
Member's DOB:	Contact Person (Name, Phone & Fax # :)
Employer Group's Name & Phone #:	Requesting Provider's Signature or Stamped Signature:
Other Insurance(s):	
Diagnosis (incl. ICD-10 code):	Procedure/Treatment Request (incl. CPT code): Number of Treatments Requested _____ Inpatient / Outpatient: Services Requested by Patient: *YES* *NO*
Service Provider / Address / Phone #:	Place of Service / Facility and Address: Requested Procedure Date / Start Treatment Date:

Area for internal health plan use only	Authorization:		Date of Authorization:	Pended / Denied: (Reason):
Health Plan Contact name & phone #:	Yes	No	Authorization Number:	

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.*

**** 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.

The information contained in this form, including attachments, is privileged and confidential & is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or the agent responsible to deliver to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.

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S4590 (09/19)