LifeWise
Health Plan of Washington

FAX TO UM
If questions, please call UM

UM Fax: 888-613-1497
UM Phone:844-996-0333

Requestor's Contact Name:				Requestor's Contact #:					
Patient Information:									
*Name:				*DOB:					
*Member ID #:				*Member Phone #:					
Work Related Injury?	☐	Yes	☐	No	Motor Vehicle Accident related injury?	☐	Yes	☐	No
Does the member have other insurance?	☐	Yes	☐	No	If Yes, other insurer				
Does the member have Medicare?	☐	Yes	☐	No	If Yes,	☐	Part A	☐	Part B
*Service Is: ☐ Elective / Routine			☐ Expedited / Urgent			☐ Retrospective Review			

Note: Select Expedited/Urgent to prevent serious deterioration in health or jeopardize ability to regain maximum function.

(For Claim Denial or Prior Authorization Denial, please submit an Appeal through Customer Service at **1-800-817-3056)**

***Referral Service Type Requested:** Please review plans benefit prior to request

Inpatient	Outpatient	Behavioral Health	Other
☐ Emergent Inpatient	☐ Surgical Procedure	☐ Inpatient	☐ Home Health /Skilled Services (SN/PT/OT/SP)
☐ Concurrent Review	☐ PT, OT, ST	☐ Partial Hospitalization	☐ Private Duty Nursing
☐ Surgical Procedures	☐ Imaging	☐ Intensive Outpatient (IOP)	☐ DME
☐ Elective Admission	☐ Chiropractic	☐ Residential Treatment	☐ Transportation / Transfers
☐ Elective Observation		☐ Mental Health & Substance Use Disorder	☐ Air Ambulance
☐ SNF		☐ ABA Therapy/Services	☐ Other:
☐ Rehab		☐ Other Therapy:	
☐ Maternity			
☐ NICU			

Procedure Information:		
***ICD 10** Diagnosis:	Diagnosis Description:	
***CPT/HCPC** Code & Description *(Include Unit of Measure / Frequency for supplies):*		
*Date(s) of Service:	Number of Visits:	
Provider Information:		
Ordering Provider	Is this the member's Primary Care Physician? ☐ Yes ☐ No	
*Name:	*NPI:	TIN:
*Phone:	*Fax:	
*Address:		
Servicing Provider	Is this the same as the Ordering Provider? ☐ Yes ☐ No	
If not complete below:		
*Name:	*NPI:	TIN:
*Phone:	*Fax:	
*Address:		
Facility		
*Name:	*NPI:	TIN:
*Phone:	*Fax:	
*Address:		
Request for extension to authorization request:		

ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NECESSITY. INCOMPLETE INFORMATION MAY DELAY THE PROCESS. Always verify eligibility, benefits and prior authorization requirements