# Washington Transition of Authorization

If you are a new member of a UnitedHealthcare plan and were granted a prior authorization from your previous health plan carrier, UnitedHealthcare will cover the services included in that prior authorization for at least 30 days from the day you began coverage with UnitedHealthcare. In order to receive coverage, you must complete this form, include a copy of the previous carrier's approval letter and provide a copy of the previous carrier's market withdrawal notification, if applicable.

## Step 1

**To begin the Transition of Authorization process, please contact UnitedHealthcare at 877-842-3210.**

## Step 2

**To complete this form:**

- Please complete and return this form within 30 days from the first day you became covered by a UnitedHealthcare plan.
- Please attach a copy of the previous health plan's prior authorization documentation, such as an approval letter.
- Please make sure all fields are complete. When the form is complete, it must be signed by the member for whom the Transition of Authorization is being requested. If the patient is a minor, a guardian's signature is required.
- You must complete a separate form for each prior authorization from your previous health plan carrier.
- Please fax this completed form along with your prior authorization documentation within 30 days following the effective date of your UnitedHealthcare plan to **1-800-696-8151**.
- After receiving your request, UnitedHealthcare will review and evaluate the information provided. Incomplete forms will be returned to the requester. If the form is complete, we will send you a letter to let you know that we will provide coverage for the services.
- If you need additional services after 30 days, you will be required to follow your UnitedHealthcare plan requirements.
- For Behavioral Health services, please contact your behavioral health carrier by calling the customer services phone number on your health care ID card.
- Claim will be administered at the appropriate benefit level based on network status of Provider.

| **Member Information** | | |
|---|---|---|
| Patient Name | Member ID Number | Patient's Date of Birth (mm/dd/yyyy) |
| Address | City | State/Zip Code |
| Home/Cell Phone Number | Work Phone Number | |
| Employer Name | Date of Enrollment in the Plan (mm/dd/yyyy) | |
| Member's Relationship to the Employee: ☐ Self ☐ Spouse ☐ Dependent ☐ Other | | |
| **Authorization to release records:** I authorize all physicians and other health care professionals or facilities to provide UnitedHealthcare information concerning medical care, advice, treatment or supplies for the member named above. This information will be used to determine the member's eligibility for Transition of Authorization benefits under the plan. | | |
| Member's Signature/ Parent or Guardian's Signature if Member is a Minor | | Date (mm/dd/yyyy) |

| **Care Provider Section - Your health care professional should complete the following information:** | | |
|---|---|---|
| Requesting Provider Name | National Provider Identifier (NPI) or Tax ID Number (TIN) | Phone Number |
| Address | City | State/Zip Code |
| Hospital/Outpatient Facility Name & Tax ID Number (TIN) | | Hospital/Facility Phone Number |
| Servicing Provider Name (if different from Requesting Provider) | National Provider Identifier (NPI) or Tax ID Number (TIN) | Phone Number |
| Address | City | State/Zip Code |

| | |
|---|---|
| Diagnosis | CPT Codes Approved |

| | | |
|---|---|---|
| UnitedHealthcare Service Reference Number (SRN) | Dates of Service (mm/dd/yyyy) Approved | Visits Approved (if applicable) |

| | |
|---|---|
| Drug Name if applicable: | Units Approved (if applicable): |

Place of Service:
- ☐ Inpatient
- ☐ Outpatient
- ☐ Acute Hospital
- ☐ Inpatient Rehab
- ☐ Skilled Nursing Facility
- ☐ Home
- ☐ Office
- ☐ Hospice

Services Requested:
- ☐ DME
- ☐ Pharmacy
- ☐ Hospice
- ☐ Surgical
- ☐ Medical
- ☐ Transportation

**Current and Associated Treatment(s)/Comments**

The above-named patient is a UnitedHealthcare member. We understand you are a participating provider in the UnitedHealthcare network. Please note the following:

- If applicable, payment under your participation agreement, together with any copayment, deductible or coinsurance for which the member is responsible under the plan is payment in full for the covered service and you will not seek to recover, and will not accept any payment from the member, UnitedHealthcare, or any payer or anyone acting on their behalf, in excess of payment in full, regardless of whether such amount is less than your billed or customary charge.
- Upon request, you will share information regarding the member's treatment with us.
- If applicable, you will make referrals for services including laboratory services, to network providers in accordance with the terms of your participation agreement.

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|---|---|
| Signature of Health Care Professional | Date (mm/dd/yyyy) |