

Authorization does not guarantee payment, which is affected by other factors, such as eligibility, benefit limitations, exclusions and other coverage issues.

**Unison Health Plan of Ohio**  
**Prior Authorization Fact Sheet**  
**Utilization Management Phone #: 1-800-366-7304**

**\*\*Fax completed form to the Utilization Management Department (866) 839-6454\*\***  
**A Unison representative will call with an authorization decision within 2 business days**

**Member Information**

Member Name \_\_\_\_\_ Member ID # \_\_\_\_\_ DOB \_\_\_\_\_

COB/Type \_\_\_\_\_ Member's PCP \_\_\_\_\_

**Provider Information**

Requesting Provider Name \_\_\_\_\_ Provider ID # \_\_\_\_\_

Phone # \_\_\_\_\_

Requested Place of Service \_\_\_\_\_ Provider ID # \_\_\_\_\_

Previous Authorization (if applicable) \_\_\_\_\_

Contact for authorization questions \_\_\_\_\_

**Requested Service Information (i.e. Therapy, Homecare, Chiropractic, Pain Management, CT, MRI, Outpatient Surgery, etc...)**

Date of Service \_\_\_\_\_ Service being requested \_\_\_\_\_ # of Visits \_\_\_\_\_

ICD-9 Code(s) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

CPT Code(s) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name of Medication \_\_\_\_\_ NDC/J-Code \_\_\_\_\_ Dosage \_\_\_\_\_

# of Doses \_\_\_\_\_ Duration \_\_\_\_\_

**Supporting clinical and treatment plan related to above request**

Symptoms \_\_\_\_\_

Past medical history \_\_\_\_\_

Diagnostic testing or conservative treatment prior to request \_\_\_\_\_

**Please note you may attach any other applicable clinical information. A current MD order should accompany all Homecare and Therapy requests. All decisions are based on medical necessity.**