

## Unison MedPLUS Prior Authorization Program Exception Form

ID Number	Last Name	First Name
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Requesting Practitioner	ID Number	Telephone Number
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Service Practitioner	ID Number	Telephone Number
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Street Address/ City/State/Zip
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Member's current residence- (SNF,PCH Home, Hospital, etc)-	Primary Diagnosis/ ICD-9 code	Secondary Diagnosis/ ICD-9 code
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Description of Service Requested	Code (s)	Billable Charges
	Requested Date of Service	Estimated Length of need

Alternative Treatments utilized prior to this request:
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Brief narrative describing what symptoms/abnormalities the service requested is intended to alleviate/medical justification:
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\*If you are requesting DME items, please attach a copy of the manufacturer's specification sheet, and the manufacturer's suggested retail price per unit / item.

Ordering Physician Signature	Date
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### Unison MedPLUS use only

UM Coordinator	Authorization number
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