UM Department Request Form - Highmark

Today's Date: _____/_____/_____ **Authorization #** _____

Patient Name: _____ **Patient ID #** _____

Practitioner Name: _____

Instructions:
1. Please fax this form to Healthways @ **1-888-492-1029**
2. Please complete **one section only** and check appropriate box prior to submission.
3. If you have any questions please call Healthways @ **866-656-6072**

Extension of Authorization End Date: 10 Days ☐ 20 Days ☐ 30 Days ☐

To request an extension of the treatment timeframe **(end date)** on visits previously authorized but not yet utilized.

Please Note: One (1) date extension will be considered per episode of care with a maximum of thirty (30) days. Request must be received within 30 days from end date of prior authorization

Request for Peer-to-Peer Discussion: ☐

To request a discussion of the outcome of the clinical review completed by the peer reviewer who made the determination. **This is not considered a formal appeal**. A reviewer will be available to discuss the case within one (1) business day of receipt of the request. Please provide a phone number and the best day and time to reach you.

Phone number: _____

Best days & times to call: (Option 1) _____ (*Day*) /_____ (*Time*) (Option 2) _____ (*Day*) /_____ (*Time*)

Please Note: The HWHN peer reviewer will attempt to accommodate the options for the call to your office. Also, see determination letter we previously sent for time limits to file your request.

Practitioner Appeal of a Medical Necessity Determination: ☐

If you disagree with a medical necessity review outcome, you have the right to request an appeal. A peer reviewer other than the one that made the original determination will review the file. You may provide additional information to support your request.

Please Note: See determination letter we previously sent for time limits to file your request.

TIPS:

- Use the UM Department Request form to request end date extensions, start date adjustments, Peer-to-Peer Discussions and/or provider appeals. Please fill out the top portion of the form in its entirety.
- When requesting an extension of Authorization End Date, **please be sure to check the appropriate box.**
- When requesting an adjustment of the authorization start date, please fill out the top portion in its entirety and hand write the start date adjustment request on the form (i.e. ***"Please adjust auth start date to MM/DD/YYYY***").
- When requesting a Peer-to-Peer Discussion, please be sure to include **TWO** (2) best call times.
- **Please note**: the times provided are not a guaranteed time for call. The Healthways peer reviewer will attempt to accommodate the options for the call to your office.